Division of Vital Records, P.O. Box 68760

Registrar DHMH 17 Rev 06-2011

State

dew

30. Name and address of person who completed cause of death

ANTHONY

31. Date filed (Month, Day, Yea

B/BAKYE MO

BES

(Item 23a) (Type, Print)

32. Registra's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ lanche Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Upper Marlboro Prince Georges 5701 S. Marwood Boulevard If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Numbe Are (In vrs. last birthday) 8. Date of Birth **Funeral** Hours Min. (Month, Day, Year) 221-24-5690 Director 1 🗌 M 2 🗓 74 03/13/1938 MD r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland **Funeral Director** 1 Tes 2 X No Prince Georges Upper Marlboro 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 5701 S. Marwood Boulevard 20772 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify: White 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 l h and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Ravmond Barr permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Once. Esther Decker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dean Rosa / Son 4300 Talmadge Circle, Camp Springs, MD 20746 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date unk 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Arlington National Cem. Arlington, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 21. Signature of Funeral Service Licensee Wary J. Gori 8200 Jennifer Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw shock, or heart failure. List only one cause on each line nset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): eral **Director:** After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months
1 Yes 2 No Month Dav Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death? performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 PResidence 6 Other (Specify) 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 D Pending Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Martical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated 29b. Signature and title of certifier signed (Month, Day, Year) 01 Name and address of person who completed cause of death (Item 23a) (Type, Print) NEUL 10 31. Date filed (Month, Day, Registra State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day RAILE EWELLYN Physician/ 2012 9:30 NOV Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. . Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 212-54-6170 Director 1 □ M 2 🗶 F 96 5/9/1916 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location Director 1 X Yes 2 ☐ No Calvert Huntingtown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 3900 Harrison Lane 20639 USA be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc . 01 by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 XWidowed 4 Divorced White Completed Year or Dates . Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natur jury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Kirby Sutton Mary Murvin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Herbert E. Railey, Jr./Son | 11700 Jester Court, Dunkirk, MD 20754 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Department of H Important: If ite any injury or ot once. 1 Burial 2 X Cremation 3 Removal from State 11/17/12 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crem. Beltsville, MD permit. 22. Name and Address of Facility Raymond-Wood F.H., P.A. 21. Signature of Funeral Service Licen PO Box 430, Dunkirk, MD 20754 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ovenary Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine burial-transi Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicia etely filled in by the funeral director, page 2 should be detached for use as the but Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year 2 X No 1 ☐ Yes ∠ ⋈ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ idner 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 1 Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 Inpatient 2 KER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11-16-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) dRW 5 Prived Frederich 20678 100 Hospita John Wichae Registra State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40504 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month 6:05 A M Mary E. Rice 2012 29 11 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WMHS Frostburg Nursing& Rehab.Center Frostburg Allegany 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** , Day, Year) May 16, 1926 Min Days Hours Maryland Director 216-22-5981 1 M 2 X F 86 Usual Residence of Dece or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Allegany Mount Savage Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò r than "natural", or items 23a o the Medical Examiner must be 16109 Calla Hill Road by Funeral Page 1 and 2 should be filed within 72 hours after death with U.S.A. 21545- Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11 Marital Status Armed Forces Black, White, etc. Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Specify. 3 Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) nt of Health and Mental Hygiene.

If item 27 is marked other that or other traumatic event, the I Hair Salon Cosmetologist 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Deffenbaugh Helena Brannon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21532-Maryland Donald C. Rice husband 48 Tarn Terrace Frostburg 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. Maryland Veteran's Cemetery Flintstone Maryland December 03, 2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 Tobala. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician/ congestive fmonthe disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any learny to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence of executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Year signed by the a 1 ☐ Yes ∠ ↓ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Hospital Other: 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury 1 Natural 2 Accident 5 Pending nours after death.
neral Director: Af 1 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Hospital or Attending Physician: The law requires that the death certificate be 24 hours Medical within 24 hor To the Fune completely fi 2 Hodical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Do055325 NOV 29, 2012 muelto 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Comportand MD 21502 walsh 31. Date filed (Month, Day, Year) NOV 30 2012 State Registrar DHMH 17 Rev 06-201 ORIGINAL

Physician /Medical Examiner the death certificate be executed

Funeral

Director

Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the <u>Medical Examiner must be notified at</u>

death

filed within 72 hours after

Pages 1 and 2 should be

Maryland 21215-0036

Baltimore,

P.O. Box 68760

Division or Vital Records,

or Attending Physician;

the Hospital

the burial-tran physician as attending p the detached cate has been signed I page 2 should be det funeral director, After this within 24 hours after death To the Funeral Director: completely filled in by the I

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🛛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

State

Vijay Karumbunathan, 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) 2012

30. Name and ad 1935 of person who completed cause of death (Item 23a) (Type, Print)

MD. - 201 Hall Highway _ Crisfield, MD 21817

NOV 1 9 2012

32. Registrar's Signature 9. pares

Registrar

			_ FOF	partment of Health and Menta ertificate of Death	Reg. No.2012 40506
	Dhusisis	/	Decedent's Name (First, Middle, Last)		e of Death 3. Time of Death
	Physicia Medio		Grace Roccella		ember 17 2012 7:58P M
mod	Examin	er	4a. Facility Name (if not institution, give street and number) 19212 Willow Grove Road	4b. City, Town, or Location of Death	4c. County of Death Montgomery
-	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	Olney If Under 1 Year If Under 24 Hrs. 8. Dat	e of Birth 9. Birthplace (State or Foreign
l.	Director		579-44-4478 1 □ M 2 ⅓F 85 Yrs.		onth, Day, Year) Country) Ly 10 1928 Washington, D.C.
	nd how at	٦	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L		10d. Inside City Limits
	flaryla 8a-f s tified	Director	MD Montgomery Silve	r Spring	1 ☐ Yes 2 ⊠ No
	a or 2 be no		10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	ith with	Funeral	15115 Interlachen Drive, Apt. 516	20906	United States
9	er dea or ite miner	by Fu	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼ Never Married 2 □ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ ∀as 2 ▼ No	Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, e	14. Race - American Indian, Black, White, etc. White
003	urs aft ural", Il Exa	ted t	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1 Yes 2 No Specify:	Specify: WILLCE
15-(72 hor n "nat ledica	Completed	(Specify only highest grade completed) (Givi	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
21215-0036	ed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at		Elementary/Secondary (U-12) College (1-4 or 5+)	ales Person	Retail Sales
pu	tal Hy	To Be	17. Father's Name (First, Middle, Last) Joseph Roccella	18. Mother's Name (First, Jennie	Middle, Maiden Sumame) Pilla
Maryland	2 should be fill th and Mental ?7 is marked of traumatic eve	-		ling Address (Street and Number or Rural Route	
	2 sh shar 17 is trau		1131.	27 Briarwood Terrace,	
Baltimore,	e 1 and 2 tof Healt If item 2 or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposered Computery, Cremetery, Cremete	position (Name of Date ematory or other place)	20c. Location - City or Town, State
tim	permit. Page 1 Department of Important: If i any injury or c		4 Donation 5 Other (Specify) Gate of	Heaven Cem. 11/24/12	
Bal	permit Depar Impor any in				V. Barber Funeral Home Onsville, Maryland 20882
			23a. Part 1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.		
	Physician/		Immediate Cause (Final disease or condition Metastatic sa	rcoma of ovary	Onset and Death 6 months
-	Medical Examiner		resulting in death) Due to (or as a consequence of):		
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		
	executed an and irial-transit	Examiner	Cause (Disease or injury that initiated events c		
_	b ci	ical E	resulting in death) Last Due to (or as a consequence of):		
200		ledic	d		
Box 6876	eath certificate attending phy for use as the	an/N	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1	☐ Ectopic pregnancy	23d. Date of delivery
Bo	Attending Physician: The law requires that the death certificate redeath. **rdeath.** **ector**, the attending phy ector**, page 2 should be detached for use as the by the funeral director, page 2 should be detached for use as the content of the page 2 should be detached for use as the page 2 should be detached for use as the page 2 should be detached for use as the page 2 should be detached for use as the page 2 should be detached for use as the page 3.	Physician/Med	1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 ☐ Unknown	Other (specify)	Month Day Year
P.O.	that the deaned by the and detached		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	e. Did tobacco use contribute to the cause of death?
ds,	v requires that s been signed t should be det	ted b			1 Yes 2 No 3 Probably 4 Unknown
cor	has be ge 2 sh	Completed by		24	a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
I Re	ician: The la certificate ha rector, page	e Cor	25. Was case referred to medical	1 1 26. Place of Death (Check only or	☐ Yes 2 🗷 No 1 ☐ Yes 2 ☐ No
Vita	ysician: is certific director,	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati	Other:	Residence 6 ☑ Other (Specify)
of	ng Phys fter this uneral di		27. Manner of Death 28a. Date of injury (Month, Day, Year) injury injury	of 28c. Injury at 28d. De work?	scribe how injury occurred
sion	Attending Pher death. ector; After the by the funeral	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	cation (Street and Number or Rural Route Number,
>			4 Homicide determined building, etc. (Specify)		y or Town, State)
	To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in	Medical	29a. Certifier 1 ☑ Certifying Physician: To the best of my knowledge, death (Check 2 ☐ Medical Examiner: On the basis of examination and/or inve	estigation, in my opinion, death occurred at the time	e, date and place, and due to the cause(s) and manner stated.
	To the within 2 То the сотрые	Ž	only one) 3 ☐ Certifying Nurse Practitioner: To the best of my knowledgen 29b. Signature and title of certifier	e, death occurred at the time, date and place, and 29c. License number	due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)
)		Just M Janelyn	D 35996	November 19, 2012
	6		30. Name and address of person who completed cause of death (Item 23a) (Type, Linda Burrell, M.D. 2730 Univers	Print) ity Blvd., #400, Wheat	ton, MD 20902
	Stat			pare	
	Registra	ai	The state of the s		

Registrar

State

Marrion Maryland 21215-0036

enate, altimore, l

Box 68760

P.O.

Records,

Division of Vital

9715 Healthway Dr,

Berlin,

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2012

MD,

Registrar's Signat

William H. Robins,

31. Date filed (Month

November 26, 2012

21811

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 40508 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 9:39 PM 1.1./1.9/201.2 <u>Perry E. Simpson</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MedStar St. Mary's Hospital St. Mary's <u>eonardtown</u> 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Hours Min. (Month, Day, Year) **Director** 1 X M 2 🗆 F 246-48-2815 01/27/1932 Usual Residence of Dece 80 NC 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location must be notified at Director MD Charles White Plains 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 23a Funeral 7705 Chesterfield Ct. 20695 items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Medical Examiner rmed Forces?

X Yes 2 No Black, White, etc. O þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: Black 'natural", 3 Widowed 4 X Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Business Owner Landscaping traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Leander Simpson Lessie Pone 2 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a 7705 Chesterfield Ct., White Plains, MD 20695 Rosa M. Hamilton / daughter other 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date of . cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Department of Important If any injury or once, ō 4 Donation 5 Other (Specify) Mew Light Ch. Cem. 12/01/2012 White Oak, NC 22. Name and Address of Facility Strickland Funeral Services uneral Sen Signatu 6500 Allentown Rd., Camp Springs, MD 20748 23a. Palt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiac disease or condition Medical resulting in death) **Examiner** Chow Obcour Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner K. Ince and the burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Month Day Pregnant at time of death signed by the at the detached for g Unknown Division of Vital Records, P.O. been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe this certificate has No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 욘 1 🔲 Inpatient 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of al or Attending Pl s after death. I Director; After th 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined within 24 hours a To the Funeral C To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 75m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 29 Registrar's Signature Date filed (Month) State

DHMH 17 Rev 06-2011

Registrar

ARAJA

MAGA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 40509 State of Maryland / Department of Health and Mental Hygiene 2 1 2 1 - State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Claudine Caldwell Smith November 17, 2012 8:45 P.M Medical As Facility Name (if not institution, give street and number)
St. Thomas More Nursing and
Rehabilitation Center 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hyattsville Prince Georges 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours Davs 243-66-7503 **Director** 1 M 2 X F 72 April 16,1940 North Carolina Usual Residence of Decedent 28a-f show 10c. City, Town or Location aţ 10d. Inside City Limits Director must be notified College Park Maryland Prince Georges 1 X Yes 2 No 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 9211 Davidson Street 20740 United States items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 1. Marital Status Examiner Black, White, etc or. ò 1 Never Married 2 X Married 2 **X** No 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2X No Specify: **Black** ian "natural", Medical Exar Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Montgomery County Elementary/Secondary (0-12) College (1-4 or 5+) the Maryland Public Schools should be filed with and Mental Hygien is marked other th llth grade Custodian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ Clyde Nathaniel Caldwell Mary Magdalene Jones 9a. Informant's Name/Relationship (Type, Print)
Warren Brown Smith, Jr. (Husband) 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other traumonce. Patricia Merteal Williams (Daughter) 4914 - 70th Place; Hyattsville, Maryland 20784 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory, Inc. gnature o Funeral Service 22. Name and Address of Facility R. N. Horton Company Morticians, M01421 Inc.;600 Kennedy Street, N.W.; Washington, D.C.2001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician End Stage Liver Disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner End Stage Renal Disease 6 months Sequentially list conditions, Examiner If any leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical death certificate be Box 68760 the ding IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death the P.O. ed by signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Cirrhosis of Liver 1 Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy performed? Yes 2**X** No page certificate 2 🗌 No 1 Yes Division of Vital 25. Was case referred to medical Hospital or Attending Physician: 26. Place of Death (Check only one) Be Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) Hospital: 1 ☐ Yes 2 🛣 No ည 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After X Natural iniury 5 \square Pending work? 1 ☐ Yes 2 ☐ No death. after death Director: A d in by the f Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined n 24 hou.. the Funeral Dire Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the I

complete only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 06-2011

MSIM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Neeraja Tandra, M.D.

0 2012

31. Date filed (Month, Day, Year,

D0074546

Riverdale, Maryland

November

6510 Kenilworth Avenue; Suite 1400

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Al-Sawab JH Sa		State - For State	e of Maryland /			and Mental H	ygiene	201	2 40510
		Registrar		Certificate	or Death		Reg	No.	2 Time of Death
Physicia Medical Exami		1. Decedent's Name (First, Middle, La	TH.	Sawah			Date of Death Month November 2	Day Year 25, 2012	3. Time of Death 2111 hrs
		4a. Facility Name (if not institution, g Sinai Hospital	ive street and number)		4b. City, Town	n, or Location of Death re		4c. County of De	ath
Funeral		5. Social Security Number 6.	Sex 7. Age	(In yrs. last birthday)	If Under 1	Year If Under 24Hrs	8. Date of Birth	(MM/DD/YYYY) 9. I	Birthplace (State or
Director		153-78-1245	X M 2□F	27	Months Yrs.	Days Hours Min.	08-29	-1985 For	eign Country) Organge, NO
Á.		Usual Residence of Decedent 10a. State 10b. County	/	10c. City, Town or Lo	cation				10d. Inside City Limits
# A		MD RIL		-					1 Yes 2 No
yland f show	٥	10e. Street and Number	more	1065		da	Lio	Citizen of What C	
ith the Maryland 23a or 28a-f sho notified at once	Director	7// 23 / a 1/	1/ 1		10f. Zip Co	239	100	Citizen of What C	
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fler d		3 Widowed 4 Divorce	ed If Yes, Give Year	1[Yes 2	No specify:		Specify:	1ack
ours a	d by	15. Decedent's Education (Specify	l or Dates: only highest grade com			cupation (Give kind of		16b. Kind of Busines	s/Industry
72 h	lete	Elementary/Secondary (0-12)	College (1-4 or 5	5+) during	Illust of Working	g life. DO NOT use reti	ieu)	11	
within ene.	Completed	12	d		STUde	ent		College	
21215-0036 uld be filed within ?! I Mental Hygiene. marked other than ic event, the Media		17. Father's Name (First, Middle, La					(First, Middle, Ma	aiden Surname)	
2121 Muld be fi Mental marked	Be	19a. Informant's Name/Relationship		196	iling Address (Street end Number or I		ones	ato Zin Codo) (VZ IV)
MD 2 d 2 shoul lith and N m 27 is m	٩	Page 10 Carrier Relationship	14.4	30	Mall	Street end Number of I	Alaria	er, City of Town, St	il Terrel
ore, MD 2 ss 1 and 2 shou of Health and h If item 27 is n or traumatic	H	20a. Method of Disposition	o, 1 10Th	20b. Place of Dis	position (Name of	of cemetery,	Date Date	20c. Location - City	or Town, State
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timen trant	ļ	4 Donation 5 Other Speci		Porrest (Treen Le		30/30//	Uld Drie	140, 100
Balti permit. Departm Imports		21. Signature of Funeral Service Lic	ensee	1/47/	2. Name and Ad	dress of Pacility 2%	pel or E	den Funch	1/TATALE
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/Medical		failure. List only one cause on	each line.		or the mode of a	y ig , 000 00 00 01.00 0	i reopii atory arroc	A, orlow, a ribar	Between Onset and Death
kaminer		Immediate Cause (Final disease or condition resulting in death)	A Multiple Gunsho		· · ·				Degari
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68° certifi ding	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth	time of death 5	Fetal death	3Ectopic pregna	ancy	Month	Day Year
30X death e atter for u	ysic	1 Yes 2 No 9 Unkno	7	time of death 5	Other (Specify,)		1	
O. E t the c by th ached		Part II. Other significant condition	s contributing to death	n but not resulting in the	ne underlying ca	use given in Part I.	23e. Did tob	acco use contribute	to the cause of death?
P.(es that igned be det	ğ						1 Yes	2 No 3 P	robably 4 Unknown
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COF law r : has b	힅						autops	ned? death	
Re: The ficate frage		05.111		 	00	Discoult (Observe	1 ✔ Yes 2	No 1	Yes 2 No
1 of Vital Recing Physician: The After this certificate funeral director, page	å	25. Was case referred to medical examiner?	Hospital: 1 / Inpatie	nt 2 ER/Outpati		Place of Death (Check		Residence 6 0	her:
of V Physical things	은	1 ✓ Yes 2 No 27. Manner of Death				: Injury at Work?		ow injury occurred	101.
on o ading th.	ertification:	1 Natural 5 Pending	28a. Date of Inju (Month, Day Y Nov 25, 2012	eer) 1855 hrs		Yes 2 V No	Subject shot	,,	
Divisior pital or Attend ours after death eral Director: filled in by the	cat	2 Accident Investig	ation 28e Place of In	jury - At home, farm, s	treet factory of		28f Location (St	reet and Number or	Rural Route Number, City
Divi	Έ	3 Suicide 6 Could n	ot be		street, lactory, or	mee bailding, etc.		ate) .achlan Circle, To	
Lospit Hour Uners	ပ	29a. Certifier	(орос.), Др.		coursed at the ti-	mo data and alass			
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Boapital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funantal Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri.	Medical	(Check only	ician: To the best of m ier:On the basis of exa and manner stated.	The state of the s					
F 3 F 8	ž	29b. Signature and title of certifier	/		29c. L	icense number		29d. Date signed (Month, Day, Year)
	Ì	/_	1	<u> </u>		D.C.M.E.		November 26,	2012
JH.	ł	30. Name and address of person wh	completed cause of c	leath (Item 23a)					
		Russell Alexander MD	Assistant Medic	al Examiner 9	00 W. Baltim	nore Street, Baltir	nore, MD 212	23	
	tate	31. Date filed (Month Day, Year)	012 32 Begiste	re Signature.	aus.	-			
Regis	trar	18010 0	MEN	-	8				

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene

48 UZ. KUSSETT AVC	year 25 SM of Death
Examiner 4a. Facility Name (if not institution, give street and number) 48.02 Russell Ave 4b. City, Town, or Location of Death 4c. County Hyattsville Prin	of Death
4802 Russell Ave Hyattsville Prin	
Land Annual Market Mark	ce Georges
Funeral Month, Day, Yearl,	9. Birthplace (State or Foreign Country) NC
Usual Pasidance of Danadant	NC
Per September 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
MD Prince Georges Hyattsville 10e. Street and Number 10g. Citizen of V	
The state of the s	·
11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race Blace	e - American Indian, ck, White, etc.
1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates.	Black
3 X Widowed 4 Divorced Pear or Dates. 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) St. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) St. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SAles Clerk Priva	usiness Industry
College (1-4 or 5+) Sales Clerk Priva	te Industry
17. Father's Name (First, Middle, Last) Willie Thompson Sarah S. Graham	
Willie Thompson Sarah S. Graham	
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Some Society of Street and Number or Rural Route Number, City or Town, Society of Society of Street and Number or Rural Route Number, City or Town, Society of S	
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, grematory or other place) 20a. Method of Disposition 3 Bemoval from State cemetery, grematory or other place)	- City or Town, State
1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility Latney's Funer	
Description of the purpose of the pu	gton,DC 20011
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,	Approximate
Immediate Cause (Final disease or condition Atheros of the Cartio vas cular Heart D	Onset and Death
Medical resulting in death) Due to (or as a consequence of):	
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Sign of the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy in the past 12 months? 4 □ Pregnant at time of death 5 □ Other (specify)	ate of delivery onth Day Year
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	3 ☐ Probably 4 ☐ Unknown Were autopsy findings available
24a. Was an autopsy performed? 1 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	prior to completion of cause of death?
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28d. Describe how injury occurry Natural 5	per or Rural Route Number,
	ner as stated
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manny opinion, death occurred at the time, date and place, and due to the cause(s) and manny opinion, death occurred at the time, date and place, and due to the cause(s) and manny opinion, death occurred at the time, date and place, and due to the cause(s) and manny opinion, death occurred at the time, date and place, and due to the cause(s) and manny opinion, death occurred at the time, date and place, and due to the cause(s) and manny opinion, death occurred at the time, date and place, and due to the cause(s) and manny opinion, death occurred at the time, date and place, and due to the cause(s) and manny opinion	ue to the cause(s) and manner stated.
29b. Signature and title of certifier 29c. License number 29d. Date signe	ed (Month, Day, Year)
	mesons, rate
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAIVA door Sulva Ter 30-1 Hospital Dring Cheverly M.	myland
State 31. Date filed (Month, Day, Year) 34. Registrar's Signature Registrar NOV 2 0 2012	

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	Physicia Medi		1. Decedent's Name (First, Middle, Last) Robert M. Shuski						2. Date of De Month Novemb	Dav	2012	3. Time of Death 4:00 A M
	Examir	ner	4a. Facility Name (if not institution, give street and number) Genesis HealthCare			Rock	ville			4c. Count	ty of Death	ry
	Funeral Director		5. Social Security Number 136–34–7849 6. Sex 1 M 2 \square F Usual Residence of Decedent	ge (In yrs. Ia.	st birthday) Yrs.	If Under Months		Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 09/02/	y, Year)	Coun	place (State or Foreign try) Jersey
	faryland 8a-f shov tified at	rector	10a. State 10b. County MD Montgomery	10c. City	, Town or Loc Ga		sburg				1	0d. Inside City Limits 1 ☐ Yes 2√√ No
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21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed)		16a. Deced	Yes 2	No S Occupation	Specify:	ecify Yes or No- Rican, etc.)	14. Ra Bla Specify		etc. nite
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Maryland	ld be filed Mental H larked ot atic even	To B	17. Father's Name (First, Middle, Last) Benjamin Shuski						ne (First, Middle, Skorups	Maiden Surnam	те)	
	id 2 shou salth and n 27 is m er traum		19a. Informant's Name/Relationship (Type, Print) Eileen M. Morgan(Sister)		1							odeMD, 20886 ersburg,
Baltimore,	. Page 1 an Iment of He tant: If iten jury or oth		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 🛣 Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		ace of Disposemetery, crem	tan Cre	her place) emator	Nove v 17	Date ember 2012	20c. Location	dria.	VA
Bal	permit Depart Impor any in	13	21. Signature of Funeral Service Licensee 1 RA Cy L STUVEN M	101117	22.	. Name and	Address of	Facility De	ol Fune	ral Hom	ne, 10	East
	Physician and the brial-transit the brial-transit	dical Examiner	23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each liming liming limits and cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Cerebrovation of the cause of the cause in the cause on the cause on each limit in the cause of cause on each limit in the cause on each limit in the cause of cause on each limit in the cause	e. Obstr a conseque a conseque omy Se	ructive ence of): Lar Accence of):	e Puli	monar	y Disea	se	est,		Approximate Interval Between Onset and Death
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ital	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?				26. Place	of Death (Chec		2 90 110		
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	To the Hospital within 24 hours To the Funeral C	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of only one) 3 X Certifying Nurse Practitioner: To the	xamination :	and/or investi-	gation, in m	y opinion, de	eath occurred a	t the time, date a	ind place, and du	ue to the cau	se(s) and manner stated.
	15+1		29b. Signature and title of certifier	CI	Khp	29c. l	SIZ	phoen d		29d. Date signe	od (Month, D	
			30. Name and address of person who completed cause of d Vera Ruth Reublinger, CRN						Suite 1	30, Roc	kvill	20850 e, MD
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			For	State of M	laryland	•				nd M				0	1.0	E 10
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99	certif nding use a	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			F-1- 1					ļ	23d. Date of	of delive	ry	
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	vithin o the	Σ	only one) 3 L Certifying Nu 29b. Signature and title of certifier	rse Practitioner: To the	ne best of my l	knowledge,			e time, date number	and plac			e(s) and man			
	15		Fund M	funell	1			359					7. 26,			
	, -	1	30. Name and address of person who	/	death (Item 23	3a) (Type, Pi	rint)				1					
			Linda M. Burrell		0 Univ	ersit	y Blv	d. V	West,	#400	O, Whea	ton	, MD 2	2090	2	
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		,	1 - State of Maryland / Dep Registrar Ce	artment of Health and I	Mental Hygier Reg.	
ш	Dhusisis	/	1. Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physicia Medio		Carmen Nancy Smedley			26, 2012 8:26 am
	Examir	ner	4a. Facility Name (if not institution, give street and number) Holy Cross Hospital	4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Birthplace (State or Foreign
	Director		579-58-6832 1 □ M 2 対 F 76 Yrs.	Months Days Hours Min.	(Month, Day, Yea April 28,	
	thow at		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation	11p111 20,	10d. Inside City Limits
	Aaryla 8a-f s tifled	Director	MD P.G. Silver	Spring		1 ☐ Yes 2 🛣 No
	a or 2 be no	i <u>o</u>	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	th with ms 23 must	Funeral	3154 Gracefield Road, Apt. 217	20904	- '/- V N -	USA
ယ	er dea or ite miner	by Fu	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ▼ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ▼ No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian, Black, White, etc.
003	urs aft ural", al Exa	ted	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1 🗷 Yes 2 □ No Specify Cuba	n	Specify: White
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Baltimore, Maryland 21215-0036	e filed tal Hy ed oth event	To Be	17. Father's Name (First, Middle, Last) Francisco Suarez		ne (First, Middle, Maide	en Surname)
<u> </u>	ould be d Men marke matic	-		Carmen I		T 011 T 0 11
Ma	12 sho alth an 27 is ir trau			ing Address (Street and Number or Run 4 Gracefield Road。		lver Spring, MD 20904
ore,	of Hear of Hear fitem		20a. Method of Disposition 20b. Place of Disp	osition (Name of	Date 20c	Location - City or Town, State
<u>H</u>	. Page Iment tant: I		Terbanar 2 - Ordination 5 - Herrioval nonitotate	eaven Cemetery	ov. 29, 2012 Si	llver Spring, MD
Ball	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	2. Name and Address of Facility rancis J. Collins 00 University Blyo	Funeral Ho	ome Inc. ver Spring, MD 20901
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	hysician Medical		Immediate Cause (Final disease or condition resulting in death) a. Cardiopulmonary A	rrest		Onset and Death
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		iner	Sequentially list conditions, if any, teading to infinitelate cause. Enter Underlying			
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X 68/	h certifica tending pl or use as t	an/N	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1			23d. Date of delivery
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л. Э.	that the ned by e deta	by Pi	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
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o U	tendir Jeath. Ior: Af the fu	Certificate:	2 Accident Investigation	M 1 Yes 2 No		
Division	after of after of Direct of in by	Cert	4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. Within 24 hours after death. Within 24 hours after death. South Funeral Director. After this certificate has been signed by the attending people of the properties of the funeral director, page 2 should be detached for use as south after the funeral director, page 2 should be detached for use as south after the funeral director.	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check 2 Medical Examiner: On the basis of examination and/or inve			
	the H thin 24 the F goplete	Me	only one) 3 Certifying Nurse Practitioner: To the best of my knowledge	e, death occurred at the time, date and pl	ace, and due to the cau	use(s) and manner as stated.
			29b. Signature and title of certifier	29c. License number D74417		Date signed (Month, Day, Year) Nov. 26, 2012
			30. Name and address of person who completed cause of death (Item 23a) (Type,			20, 2012
			Neeraj Mendhiratta, MD 1500 Forest	Glen Road, Silve	r Spring,	MD 20910
	Stat Registra		31. Date filed (Month, Day, Year) 3. Registrar's-Signature 100 2 2 2012	when		
	91041		1101			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40515 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 11/16/2012 LUCILLE MAY SMALL 4:30 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Montgomery 3812 Bel Pre Road, Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours (Month, Day, Year) Director 1 □ M 2 □XF 577-74-9250 Yrs. 05/29/1922 Jamaica 90 Usual Residence of Decedent or then "natural", or items 23e or 28e-f show the Medical Examiner must be natified at 10c. City, Town or Location 10d. Inside City Limits Directo Silver Spring 1 X Yes 2 □ No MD Montgamery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 USA 3812 Bel Pre Road, within 72 hours efter death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married ģ Maryland 21215-0036 1 ☐ Yes 2 X No Specify. permit. Page 1 and 2 should be filed within 72 hours eft Depertment of Heelth and Mentel Hygiene. Importent: If Item 27 is marked other then "natural", eny Injury or other treumetic event, the Medical Even If Yes, Give Year or Dates Black Specify: Completed 3 ₺ Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Domestic Domestic Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ezekiel Brown Francis M. Tavlor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3106 Anderson Avenue, Wheaton, MD 20906 Llewelyn Small/son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gate of Heaven Cem. 11/26/2012 Silver Spring, MD 21. Signature di Funeral Sendo Licensee 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cholangio Carcinoma Physician/ disease or condition resulting in death) month Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): ettending physician and d for use es the buriai-Exam The lew requires that the deeth certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? ete has been signed by the e pege 2 should be deteched i 9 Unknown P.O. Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificete has autopsy To the Hospitel or Attending Physicien: The within 24 hours after death.

To the Funerel Director: After this cartificate completely filled in by the funerel director, per 1 Yes 2 No Be 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) was case received to examiner? 1 ☐ Yes 2 ☐ No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ★ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number She oter res D21910 11/21/2012

Registrar
DHMH 17 Rev 06-2011

State

3921 Ferrara Drive, Wheaton, MD 20906

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Sherer, MD

Peter B. Shei
31. Date filed (Month, Day, Year)

NOV 27

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Molt1/20/2012 VITTA SAVAGE SHANTS 7:00 a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chevy Chase Montgomery Manor Care Nursing Home 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours Days (Month, Day, Year) Director 220-58-5019 1 □ M 2 □X= 9/4/1952 Washington, DC 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f shor 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1
√ Yes 2 □ No Wheaton Montgamery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20902 USA 2201 Parker Avenue 12. Was Decedent Ever in U.S. Armed Forces?, 1 ☐ Yes 2 ⚠ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White 3 - Widowed 4 - Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) 2+ Elementary/Secondary (0-12) Dietary Aid Nursing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Eda Scoglio Henry J. Savage 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4320 Dunwood Terrace, Burtonsville, MD 20866 Gina Butler/sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Gate of Heaven 11/28/2012 Silver Spring, MD 22. Name and Address of Facility Snowden Funeral Home of Funeral Service Licensee 21. Si m 246 N. Washington St., Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Peripheral Nerve Sheath disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate
Cause (Disease or injury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached. Exami that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 ☐ Yes 2 🖳 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🗌 No 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title certifie 29c. License number 29d. Date signed (Month. Day, Year) D35579 21 20/2 who completed cause of death (Item 23a) (Type, Print) r, 8218 Wisconsin Avenue, #305, Bethesda, MD 20814

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

NOV 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 40517 Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 20 November Charles William Schneider 9:10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Casey House-Montgomery Hospice Derwood Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min (Month, Day, Year) Director 217-32-4376 1 X M 2 D F 10/23/1935 Maryland il Hygiene. I other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Montgomery Gaithersburg 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral with 401 Russell Avenue, Apt. 20877 United States death \ 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1955—
1 2 Yes 2 No 1957
If Yes, Give 1957
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Manager Giant Food Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file of Health and Mental Hitem 27 is marked of other traumatic ever ည Frank Conrad Schneider Mary Lillian Blundon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Audrey L. Schneider/Spouse 401 Russell Avenue, Apt. 413, Gaithersburg, MD 20877 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 X Removal from State 4 Donation 5 Other (Specify) Metropolitan Crem. 11/20/2012 Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home Regan ullian MO1202 10 E. Deer Park Drive, Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physiciani disease or condition resulting in death) Dementia Medical Due to (or as a consequence of): Examine Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): requires that the death certificate be executed ending physician and use as the burill case Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown for Month Year been signed by the sahould be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗌 Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an or Attending Physician: The law page 2 s has autopsy perform certificate Yes 2 X No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 🛭 Other (Specify) Hospice 1 🗌 Yes 2 🖾 No 욘 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State)

Division of Vital Records, P.O. Box 68760 To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fur 15+1

To			
Medica	29a. Certifier (Check (Check only one) 1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and/only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, 10 Certifying Nurse Practitioner: To the best of my knowledge, 11 Certifying Nurse Practitioner: To the best of my knowledge, 12 Certifying Nurse Practitioner: To the best of my knowledge, 12 Certifying Nurse Practitioner: To the best of my knowledge, 13 Certifying Physician: To the best of my knowledge, 13 Certifying Physician: To the best of my knowledge, 14 Certifying Physician: To the best of my knowledge, 15 Certifying Physician: To the best of my knowledge, 15 Certifying Physician: To the best of my knowledge, 16 Certifying Physician: To the best of my knowledge, 16 Certifying Physician: To the best of my knowledge, 17 Certifying Physician: To the best of my knowledge, 17 Certifying Physician: To the best of my knowledge, 18 Certifying Physician: To the best of my knowledge, 18 Certifying Physician: To the best of my knowledge, 19 Certifying Physician: To the best of my knowledge, 19 Certifying Physician: To the best of my knowledge, 19 Certifying Physician: To the best of my knowledge, 19 Certifying Physician: To the best of my knowledge, 19 Certifying Physician: To the best of my knowledge, 19 Certifying Physician: To the best of my knowledge, 19 Certifying Physician: To the best of my knowledge, 19 Certifying Physician: To the best of my knowledge, 19 Certifying Physician: To the best of my knowledge, 19 Certifying Physician: To the best of my knowledge, 19 Certifying Physician: To the best of my knowledge, 19 Certifying Physician: To the best of my knowledge, 19 Certifying Physician: To the best of my knowledge, 19 Certifying Physician: To the best of my knowledge, 19 Certifying Physician: To the best of my knowledge, 19 Certifying Physician: To the best of my knowledge, 19 Certifying Physician: To the best of my knowledge, 19 Certifying Physician: To the best of my knowledge, 19 Certifyin	or investigation, in my opinion, death occurred at t	he time, date and place, and due to the cause(s) and manner stated.
	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	Alterah Miller CRA	P R143201	11.20.12
	30. Name and address of person who completed cause of death (Item 23a)	(Type, Print)	

State Registrar 31. Date filed (Month, Day, Year) NOV 2 7 201

Debrah Miller, CRNP, 6001 Muncaster Mill Road, Derwood, MD 20855

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-08816 State of Maryland / Department of Health and Mental Hygiene Richard J. Solomon 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month 0605 hrs **Medical Examiner** Richard Joseph Solomon November 20, 2012 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs, last birthday) **Funeral** 5. Social Security Number 6. Sex Days Hours Months Director 577-42-1162 85 1 X M Sept. 23, 1927 Washington, DC 2 F Yrs Usual Residence of Deceden 10d. Inside City Limits 10a. State 10c. City, Town or Location uny 1 Yes 2 K No items 23a or 28a-f shirt Silver Spring ootified at once. MD Montgomery hours after death with the Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20910 USA 1804 Forest Glen Road Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black 12. Was Decedent Ever in U.S De White etc. Armed Forces? 1 Never Married 2 X Married Specify: White 1945-47 If Yes, Give Year 1 Yes 2 X No specify Widowed Divorced Pages I and 2 should be filed within 72 hours after tent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", 6 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) umatic event, the Medical MD 21215-0036 Construction General Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alma Marie Garber Samuel Joseph Solomon Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1804 Forest Glen Road, Silver Spring, MD 20910 Joan Maureen Solomon/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery. Date 20c. Location - City or Town, State Baltimore, of I crematory or other place) 1 Burial 2 X Cremation 3 Removal from State nr other 2012 tment c Alexandria, VA Metropolitan Crematory 4 Donation 5 Other Specify 21. Signature of Funeral Service Licensee 2 Name and Address of Facility. rancis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Approximate Interval art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line Medica Death Intraoral Gunshot Wound Immediate Cause (Final disease a xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed ician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy signed by the attending phy be detached for use as the b 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Physi 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 Unknown Completed ficate has been s.; page 2 should b 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? 1 Yes 2 No Yes 2 🗸 No Tn the Hospital or Attending Physiciao: within 24 hours after death.

To the Funeral Directur: After this certificompletely filled in by the funeral director, 1 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other DOA 1 🗸 Yes 28a. Date of Injury (Month: Day, Year) FOUND: 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Subject shot self FOUND: Natural 1 Yes 2 ✔ No Pending Nov 20, 2012 0545 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 1804 Forest Glenn Road, Silver Spring, MD determined (Specify) Single Family Home Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b Signature and title of certifie O.C.M.E. November 21, 2012 a 30. Name and address of person who completed cause of death (Item 23a) Carol H. Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year, NOV 26 Registrar's Signature State

Registra

			For	oartment of Health and Nertificate of Death	lental Hygiene Reg. Nd	2012 61514		
	Physicia		Decedent's Name (First, Middle, Last) CHARLES ARTHUR SKINNER		2. Date of Death Month Da 11 2:	3. Time of Death		
)	Medic Examin		4a. Facility Name (if not institution, give street and number) 412 Washington Street	4b. City, Town, or Location of Death Cumberland		County of Death Allegany		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (in yrs. last birthday, $219-34-5900 \qquad \qquad 1 \ \text{\searrow} \text{M 2} \ \text{\square} \text{F} \qquad \qquad 73 \qquad \text{Yrs.}$		8. Date of Birth (Month, Day, Year) 10/14/1939	g. Birthplace (State or Foreign Country) Maryland		
	yland •f show ed at	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L			10d. Inside City Limits		
	the Mar a or 28a se notifi	Funeral Director	MD Allegany Cumber 10e. Street and Number	10f. Zip Code		1 ☒ Yes 2 ☐ No		
	eath with	unera	412 Washington Street 11. Marital Status 12. Was Decedent Ever in U.S. 13	21502 Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto		U.S.A. 14. Race - American Indian,		
9800	is filed within 72 hours after death with the Maryland tal Hygene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 🗓 Married 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give 163—165	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 🏋 No Specify:	Rican, etc.)	Black, White, etc. Specify: White		
Maryland 21215-0036	in 72 hol e. han "nat s Medica	Completed	(Specify only highest grade completed) (Given Elementary/Secondary (0-12) College (1-4 or 5+)	edent's Usual Occupation e kind of work done during most of worki DO NOT use retired)	ng 16b. K	(ind of Business/Industry		
ld 21	iled within I Hygiene. other tha rent, the I	Be	17. Father's Name (First, Middle, Last)	nanical Designer 18. Mother's Name	(First, Middle, Maiden	Aerospace Sumame)		
rylar	12 should be filed lth and Mental Hy 27 is marked oth r traumatic event	Jo	Leon Jackley Skinner 19a. Informant's Name/Relationship (Type, Print) 19b. Mai		dna Evans	T. 0.1. 7. 0.1.		
	nd 2 sho ealth an m 27 is ner trau		Terry Anne Murphy / Wife 41	ling Address (Street and Number or Rura 12 Washington Stree				
Baltimore,	Page 1 a nent of H int: If ite iry or oth			position (Name of permatory or other place) nd Crematory 11/2.	- 1	ocation - City or Town, State		
Balti	Terry Anne Murphy / Wife Terry Anne Murphy / Wife 412 Washington Street, Cumberland, Mi 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Structure of Funeral Structure of Funeral Hom 202 Greene Street, Cumberland, MD							
	Pnysician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not er shock, or heart dailure. List only one cause of the line. Immediate Cause (Final	ater the mode of dying, such as cardiac of \mathcal{A}_n C e \mathcal{R}	r respiratory arrest,	Approximate Interval Between Onset and Death		
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	d sit	niner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying					
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3760	ificate be g physic as the bi	Medica	d					
. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year		
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Division of Vital Records,	: The law re cate has be r, page 2 sh	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No		
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	To the	2	29b. Signature and title of certifier	29c. License number	i 29d. Dat	te signed (Month, Day, Year) 1 ember 23,2012		
	G+		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	1000			
	Stat	te	Gary Wagoner, M.D 925 Bishop Wa 31. Date files (1907) 2007 2012 32. Registrar's Synature	·	nd, MD 215	02		
	Registra		31. Date file (Month 2 arg Year) 12 32. Registrar's Synature					

			For State C	of Maryland / Depa	artment of H			giene Reg. No 20	12	40520
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Clifton E. Shirey				2. Date of Dea Month	ith	Year O12	3. Time of Death
	Examin		4a. Facility Name (if not institution, give street and nun WMHS Regional Medical Cente		4b. City, Town, or	Location of Death	nd	4c. County Alleg		
	Funeral Director		5. Social Security Number 6. Sex 1 № № 2 □ F	7. Age (In yrs. last birthday) 97 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day Augu	h (, Year) st 21, 1915	g. Birthp Count Pen	lace (State or Foreign ry) nsylvania
	tryland a-f show fied at	ctor	Usual Residence of Decedent 10a. State 10b. County Morriand	10c. City, Town or Loc		<u> </u>			11	0d. Inside City Limits
	ith the Ma 23a or 28e st be notif	Funeral Director	Maryland Allegany 10e. Street and Number 13427 McMullen		10f. Zip Code 21502-			10g. Citizen of \	What Coun	
(0	2 should be filed within 72 hours after death with the Manyland that and Mantla Hydjene. Z7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	by Fune	1 ☐ Never Married 2 ☐ Married 1 🛣 Yes	orces?	Vas Decedent of His f Yes, specify Cubar	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Rac	e - America k, White, e	
Baltimore, Maryland 21215-0036	! hours aft 'natural", dical Exal	Completed k	3 ☐ Widowed 4 ☑ Divorced If Yes, Git Year or Di 15. Decedent's Education (Specify only highest grade completed,	ates. WW 116a. Deced	Yes 2 No	ation	ina	Specify:	WII	
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e, Mai	and 2 short Health and Sm 27 is n ther traun		19a. Informant's Name/Relationship (Type, Print) Bruce Shirey son 20a. Method of Disposition	11104	Welsh Hill Ro	oad Fi	ostburg	Mai	ryland	21532-
timor	permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	Maryland \	reteran's Ceme	etery Nover	Date nber 30, 2012	Flintston	•	wn, State
Bal	permit Depar Impor any in		21. Signature of Funeral Service Licensee John H. Wu	my		eral Home, 5			g, MD	21532
\rightarrow	hy icion Medical Examiner		23a. Part 1. Enter the disease, or complications that chock, or heart failure. List only one cause on eximmediate Cause (Final disease or condition resulting in death)	ach line.	er the mode of dying)	Approximate Interval Between nset and Death
	ate be executed hysician and the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	(or as a consequence of):					+	
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Records,	The law requate has bee bage 2 short	Completed					24a. Was autop perfo 1 Yes	SV	Were autop prior to cor death? 1 Yes	osy findings available impletion of cause of
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on of	nding Phy ath. r: After thi	icate: T	27. Manner of Death 28a. Date		28c. Injury work	at		ow injury occurr		
Division of Vital	al or Atte s after dea al Director ed in by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place build	of Injury - At home, farm, string, etc. (Specify)	eet, factory, office		28f. Location (S City or Tow	treet and Numb n, State)	er or Rural	Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the ba 2 Medical Examiner: On the ba 3 Certifying Nurse Practitione	sis of examination and/or inves	tigation, in my opinio	n, death occurred a	at the time, date a	nd place, and du-	e to the cau	ise(s) and manner stated.
	2+		29b. Signature and title of certifier	Clan	29c. License	1004		29d. Date signed	25/12	y, Year)
	MR8	1	Shiv Khawka Mo	se of death (Item 23a) (Type, F	Print) Al Hai	4 1	AVALE	MD	0	1502
ı	Stat Registra		31. Date filed (Month, Day, Year) NOV 29 2012	Registrar's Signature	4					

			For State Registrar	State of Maryl		artment of F			giene Reg. No 20 1	2 40521
	Physicia		1. Decedent's Name (First, Middle, Last) RONALD LAWRENCE SH	EALLY		<u> </u>		2. Date of Dea Month	th	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give stre	et and number)	-	4b. City, Town, or		h	4c. County of	
and the same			Western MD Regiona 5. Social Security Number 6. Sex		Center	Cumber			Alle	gany 9. Birthplace (State or Foreign
1	Funeral Director				3 Yrs.	Months Days	Hours Min.		Year)	Country) Maryland
	land f show d at	tor	10a. State 10b. County		City, Town or Lo			•		10d. Inside City Limits
	e Mary r 28a-1 notifie	Sirec	MD Allegan 10e. Street and Number	у	Cumber1	and 10f. Zip Code				1 X Yes 2 No
	with th	Funeral Director	710 Gephart Drive			21502	2		10g. Citizen of Wh	
	items			Was Decedent Ever in	U.S. 13.\	Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (S	pecify Yes or No-		American Indian,
36	after cal", or	d by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates, WWI	1.	Yes 2 X No		o riioan, oto.	Specify:	White, etc. White
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21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Heath and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+) 5+	life. D	O NOT use retired)	uning most or wo	iking	Carpen	trv
d 2	led wil Hygie other ent, th	امها	17. Father's Name (First, Middle, Last)	J †	Ca	rpenter	18. Mother's Na	me (First, Middle, M	-	<u> </u>
ylan	ld be fi Menta arked atic ev	ဥ	William Thornton S	heally			Beat	rice Naom	ni Durret	t
Maryland	2 shou th and t7 is m traum		19a. Informant's Name/Relationship (Type, Ella M. Sheally /		1.0	ng Address (Street a Gephart			-	te, Zip Code) 21502
re,	of Heali of Heali fitem 2		20a. Method of Disposition	20	b. Place of Dispo	sition (Name of		Date	20c. Location - C	
Baltimore,	Page 1 ment of I ant: If it		1 ☐ Burial 2 🔀 Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State		${ m d}$ Cremato		28/2012	Cumber	land, MD
Balt	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other once.		21. Signature of Funeral Service, icenate	ochul) 22	Name and Address 202 Gree		church Fu et, Cumbe		
П			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one of		eath. Do not ente	er the mode of dyin	g, such as cardia	or respiratory arre	est,	Approximate Interval Between
8	Medical		Immediate Cause (Final disease or condition resulting in death)	Intracy	sequence of):	UlERO	(,			Onset and Death
	Examiner		Constraints lies on this or	Fall	sequence or,					
	nsit	Examiner	Goguer thally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	sequence of):	vaha			N	17
	te be executed nysician and he burial-transit	al Exa	that initiated events c. resulting in death) Last	Due to (or as a cons	sequence on:	V 0 1 CC			1 /	
200	cate be physic sthe b	ledical	d.	7-1	-121.					11/26/12
× 687	eath certifica attending p d for use as t	an/M	Zob, was accordent pregnant	If yes, outcome of pre	gnancy Fetal death 3	Ectopic pregnanc	:V		23 Date	of delivery
Box	that the death led by the att	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time 9 Unknown		Other (specify)	,		Monti	n Day Year
s, P.O.	300	þ	Part II. Other significant conditions contri	buting to death but not	resulting in the u	nderlying cause giv	ren in Part I.			ute to the cause of death?
of Vital Records,	law requires has been sig je 2 should t	Completed						24a. Was a	sy prid	ere autopsy findings available or to completion of cause of ath?
l Re	ician: The la certificate ha rector, page		25. Was case referred to medical			26 17	ace of Death (Che			Yes 2 No
Vita	ysician: is certifio director,	To Be	everniner?	pital: 1 💢 Inpatient 2	☐ ER/Outpatier	Othe	or.	Home 5 Reside	ence 6 🗆 Other (Specify)
ιof	ling Phys		27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year	28b. Time of injury	28c. Injury work	? _/	10-0	ow injury occurred	
Division	Attend r death ctor: /	Certificate:	2 X Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Flace of Injury - A		eet, factory, office	Yes 2 No	-		of Rural Route Number,
Divi	tal or / rs after al Dire led in t		4 - Homiciae determined	HOSPITAL				12500 L	n, State) Un (LwBNo	ch rp comb-
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director. After th completely filled in by the funeral	Medical	29a. Certifier (Check only one) 1 Certifying Physicia 2 Medical Examiner: 3 Certifying Nurse P	On the basis of examina	ation and/or inves	tigation, in my opinic	n, death occurred	at the time, date an	nd place, and due to	the cause(s) and manner stated.
	Vithi COT	_	29b. Signature and title of certifier	~ NN (I)		29c. License	number	100	29d, Date signed (I	Month, Day, Year)
	11+		30. Name and address of person who com	pleted cause of death (tem 23a) (Type F	Printle	066	00	11/23	1/2
V	des		Muhammad Na	com 62	5 Kp	JAVE	Sunt	204 a	imber (6	nd MD 21502.
	Stat Registra	te ar	31. Date filed (Month, Day, Year) NOV 2 8 2012	32. Registrar's Signature	gnature	/				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 40522 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 10:00Ам Tucker Yvonne 2012 November13 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6305 Riggs Road Apt# 212 Hyattsville Prince George's If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Virginia Days Hours Min. (Month, Day, Year) 220-36-5442 Director 1 □ M 2 💆 F 75 April06,1937 Usual Residence of Decedent 27 is marked other than "neturel", or items 23e or 28e-f show treumatic event, the Merkcal Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 □ No Prince George's Hyattsville MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20783 6305 Riggs Road Apt# 212 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc.
.. Black permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or leny injury or other treumatic event, the Market neturel", or length. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Private Industry Domestic Worker 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ James Tucker Marie Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Zaneta N. Green(Niece) 9906 Robstown Pl<u>ace Waldorf Maryland 20603</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Riverdale ParkCrem 1/17/2012 Riverdale Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Tyrone J. YoungFuneral Ser. 21. Signatur- Funeral Service Luchses 5635 Eads Street NE WashingtonDC 20019 23a. Part 1. Enter the disease, or complication of the shock of heart failure. List only one Immediate Cause (Final cations the used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 1 week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events Examine Due o (or as a consequence of) CUTE Exacerbation years is certificate has been signed by the ettending physician and director, page 2 should be detached for use es the burial-transit or Attending Physicien: The lew requires that the death certificete be executed resulting in death) Last Physician/Medical years Chronic Obstructive Pulmonary Disease Division of Vital Records, P.O. Box 68760 IE EEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertensive Cardiovascular disease 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Diabetes Mellitus After this certificate has performed? 1 ☐ Yes 2 🗗 No Morbid Obesity 1 ☐ Yes 2 ☐ No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 ☐ Yes 2 X No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA မှ To the Hospital or Attending Physimithin 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral directors. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 □ only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) 29c. License number D17843 November 15th, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 35M Toledo Terrace #B102 Hyattsville Maryland20782 3311 31. Date filed (Month, Day, Year) Vivek C. Vaid M.D. 34) Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

12-08586 Joseph Tustin Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	1- For State Certifi	cate of Death	Reg. No. 2012	2 4052
Physician/	1. Decedent's Name (First, Middle,Last) Joseph John Tus	tin Jr.	2. Date of Death Month Day Year November 12, 2012	3. Time of Death 1450 hrs
edicai Examinei	Joseph J. Tustin, Jr. 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		1430 1113
	1001 Fells Street	Baltimore	Baltimo	re
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last b	9 Yrs. If Under 1 Year If Under 24Hrs Months Days Hours Min	Foreign	
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Toy	vn or Location		10d. Inside City Limits
E	Florida Citrus Inver			1 X Yes 2 No
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f shown other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Coun	try?
s 23a o	705 Pineaire Street 11. Marital Status 12. Was Decedent Ever in U.S.	34452 13. Was Decedent of Hispanic Origin? (S	USA pecify Yes or No- 14. Race - Americ	can Indian, Black,
death vor item	1 Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.) White, etc.	
ural", o	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16	a. Decedent's Usual Occupation (Give kind of	Specify: Whit	
5-0036 ed within 72 hour lygiene, other than "astr the Medical Exar Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use ret	red)	iddol, y
5-0036 Iled within 72 Hygiene. d other than the Medical	1 2	Card Dealer	Casinos (First, Middle, Maiden Surname)	
21215-0036 und be filed within 7 Mental Hygiene, marked other than ic event, the Medics TO Be Comple	Joseph J. Tustin Sr.		ne A. Cannon	
Should be fand Mental 7 is marked natic event,		19b. Mailing Address (Street and Number or 705 Pineaire St., Inv		Zip Code)
re, MD 2. 1 and 2 should Health and M fitem 27 is m ar traumatic	20a. Method of Disposition 20b. Place	e of Disposition (Name of cemetery,	Date 20c. Location - City or	Town, State
Pages 1 ment of 1 hant: If i	I Dullar 2 Oremation 3 21 Nemoval nom State	natory or other place) Hill Cemetery 11/	30/2012 Philadelph	ia, PA.
Baltimore, permit. Pages I ar Department of Hee Important: If ite	21. Signeture of Funeral Service Licensee	22. Name and Address of Facility F1e	egle&Helfenbein Fu	n. Hm.
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do		e., Greensboro, MD	Approximate Interval
/Medical		Cardiovascular Diseas	e	Between Onset and Death
- Some	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.			
iner	if any, leading to immediate Due to (or as a consequence of):			
ted nisit Examiner	events resulting in death) Last Due to (or as a consequence of):			
and and	M UNPENDED	per me,g934 12-19-12	sm	
760, icate be ex physician the burial	IF FEMALE: 23c. If yes, outcome of pregnant 23c. If yes, outcome of pregnant 1		23d. Date of delivery	
Box 687 c death certific the attending of for use as t hysician/	past 12 months? 1 Live birth 4 Pregnant at time of death	2 Fetal death 3 Ectopic pregnation of the Specify)	ancy Month D	ay Year
D. Box 687 t the death certification by the attending ached for use as the Physician/	Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not result	ting in the underlying cause given in Part I.	23e. Did tobacco use contribute to	the cause of death?
ires that the signed by I be detach		ting in the didenying cause given in raint.	1 Yes 2 No 3 Prob	
of Vital Records, ag Physician: The law require After this certificate has been signeral director, page 2 should b. To Be Completed			autopsy prior to c	topsy findings available ompletion of cause of
Reco The law icate has page 2 s			performed? death? 1 ✓ Yes 2 No 1 ✓ Ye	s 2 No
Vital Revasion: The his certificate director, page	25. Was case referred to medical examiner?	26.Place of Death (Check /Outpatient 3 DOA Other,4 Nursi	only one) ng Home 5 Residence 6 🗸 Other	: Scene
of Viling Physi ling Physi After this funeral dir	27 Manner of Death	b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred	
Division that or Attendin is after death. **I Director: / led in by the fi	1 X Natural 5 Pending 2 Accident Investigation 38 Place of Invest. At home	1 Yes 2 No	28f. Location (Street and Number or Ru	ral Poute Number, City
Division or spiral or Attending hours after death. neral Director: After filled in by the fune fune fune fune fune fune fune fun	3 Suicide 6 Could not be determined (Specify)	, iaim, street, ractory, once building, etc.	or Town, State)	rai reduce Humber, Ony
	29a. Certifier 1 Certifying Physician: To the best of my knowledge, (check only one) 2 Medical Examiner: On the basis of examination end/or			
To the Ho within 24 To the Fu completed	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Mo)	
	(San Circono)	O.C.M.E.	November 13, 20)12
	36 Name and address of person who completed cause of death (Item 23: Laron Locke MD. Assistant Medical Examiner 9:	a) 00 W. Baltimore Street, Baltimore,	MD 21223	

DHMH 17 Rev 1/2001 OCME 2006

OCME

ELIA Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month November 20^{Yea} 1547 Catherine Dolores Woodard Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Prince George's Hospital Center Prince George's Cheverly Social Security Number **Funeral** 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Months (Month, Day, Year) Country) Director 577-42-6348 1 M 2 X F 80 DC 1932 Usual Residence of Dece Sept. 28a-f shov 10a State within 72 hours after death with the Maryland giena. her than "netural", or Items 23a or 28a-f sho t, the Medical Examiner must be notified at 10h Count 10c. City, Town or Location 10d. Inside City Limits Prince George's Capitol Heights 1 X Yes 2 No Maryland| ក 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funerai 1001 Elfin Avenue 20743 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married \$ Maryland 21215-0036 1 Yes 2 No Specify. Specify: African If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates American 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4 or 5+) Library Technician Government filad wit al Hygie other t æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should ba file tend Mantai F is marked or 2 Andrew Everett Sr. Beatrice Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Haeith cortant: If Item 27 Doris C. Woodard - Daughter 4328 DuBois Place SE Washington, DC Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 28 20c. Location - City or Town, State parmit. Page 1 a Dapertmant of H Important: If Ite any Injury or ot 1 🖾 Burial 2 🗆 Cremation 3 🗔 Removal from State Nov 4 ☐ Donation 5 ☐ Other (Specify) Olivet Cemetery 2012 Mt. Washington, DC 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service Licensee tema M00560 4001 Benning Road NE Washington, DC Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events Draw to for as a consequence of or Attending Physician: The lew raquiras that the death cartificate be executed resulting in death) Last Due to (or as a consequence of): ettanding physician a I for usa as tha buriei-Physician/Medicai Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Day signed by tha e 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, cata has baan sig paga 2 shouid b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this cartificata 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 K No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 XNo Other: မှ 1 😾 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work?
1 Yes 2 No Accident M Investigation 3 D Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, Medical 29a Certifie 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartific completaly filled in by the funeral director,

12 JM

State

Registrar

29b. Signature and title of certif

<u>Rachel</u>

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Registrar's Signatu

Villacortal-Lyew

8

DHMH 17 Rev 06-2011

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License numbe

D74690

3001 Hospital Drive Cheverly, Maryland 20785

			For State	of Maryland / Dep	artment of H	Health and	Mental Hyg	jiene	
			1 State Registrar	Ce	rtificate of L	Death	R	leg. N201	2 40525
П	Physicia	n/	1. Decedent's Name (First, Middle, Last)	110	alb mai	10	2. Date of Deat	h	3. Time of Death
	Medic		Alton	MES	st DY 0.0	CS	Month	Day 9 2°C	12 1044 PM
	Examin	er	4a. Facility Name (if not institution, give street and no	imber)	4b. City, Town, o	r Location of Dea	th	4c. County of D	Death
			MedStar Montgomery Med: 5. Social Security Number 6. Sex		01ney			Monte	
B	Funeral Director		254-52-4859 1 M 2 D F	7. Age (In yrs. last birthday)	Months Days	Hours Min			Birthplace (State or Foreign Country)
			Usual Residence of Decedent	75 Yrs.			July 26	, 1937 A	labama
	/land f sho	ţċ	10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	Man 28a- ootifie	Director	Maryland Montgomery	Damascus	S				1 ☐ Yes 2 🛣 No
	th the 3a or t be r	al D	10e. Street and Number		10f. Zip Code		1	10g. Citizen of What	t Country?
	ath wi	Funeral	10105 Ridge Manor Terra		20872	ii 0-ii-0 (0): N	United	
(0	er de	by F	Armed F		Was Decedent of H If Yes, specify Cuba	in, Mexican, Puer	to Rican, etc.)		merican Indian, /hite, etc.
21215-0036	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	ed k	3 Widowed 4 Divorced If Yes, G	ive	1 Yes 2 X No	Specify:		Specify:	White
5-0	2 hou "natu	Completed	15. Decedent's Education (Specify only highest grade complete	d) 16a. Dece	dent's Usual Occup	ation	orking	16b. Kind of Busine	ess/Industry
12	thin 7 than than)om	Elementary/Secondary (0-12) College	(1-4 or 5+) life. D	O NOT use retired)		innig		
d 2	ed wil Hygie other ent, th	Be (17. Father's Name (First, Middle, Last)		Engineer		The state of the s	Self Emp	loyed
Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	2		stbrook		18. Mother's Na	me (First, Middle, N Bessie	M. Jone	
ary	hould and M s mai		19a. Informant's Name/Relationship (Type, Print)		na Address (Street a	and Number or Ri	ural Route Number,		_
	id 2 salth an 27 i		Regina P. Westbrooks/Spo	10.7				•	cus, MD. 20872
ore	e 1 and of Heal If item 3 or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from	20b. Place of Dispo				20c. Location - City	
Ë	. Page tment o tant: If jury or		4 Donation 5 Other (Specify)	All Souls			3/2012	Germantow	n, Maryland
Baltimore,	permit, Page Department Important: I any injury or once.	-	21. Signature of Funeral Service Licensee				Vol Funer		
_			On Part Street						, MD. 20877
			23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on a lmmediate Cause (Final	caused the death. Do not ente	er the mode of dying	g, such as cardia	c or respiratory arre	st,	Approximate Interval Between Onset and Death
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		iner		(or as a consequence of):	1	COTT			
	rapsit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	ney Tran	spant	5			
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89	sertific Iding Ise as	Ž	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, or	itcome of pregnancy				00.1.0.1	
Box	death o	Physician/Me	in the past 12 months?	Birth 2 🗌 Fetal death 3 🖺	Ectopic pregnanc Other (specify)	у		23d. Date of Month	Day Year
O. E	the di by the	hys	g □ Unknown 9 □ Uni						
<u>Ч</u>	law requires that the death certific has been signed by the attending I a 2 should be detached for use as	by	Part II. Other significant conditions contributing to	death but not resulting in the u	inderlying cause giv	en in Part I.	23e. Did tob	acco use contribute	e to the cause of death?
Vital Records,	quire; en siç ould b	ted					1 □ Ye	es 2 No 3 E	Probably 4 Unknown
000	law re has be ge 2 sh	Completed					24a. Was an		autopsy findings available to completion of cause of
ř	The la cate ha page						perform 1 \sum Yes 2		n? Yes 2 No
ta	sician: The certificate rector, pag	œ ¦	25. Was case referred to medical examiner? Hospital:		l au	ace of Death (Che	ck only one)		
<u></u>	Phys r this eral di	욘	1 Ves 2 No 1 27. Manner of Death 28a. Date	Inpatient 2 ER/Outpatien	t 3 DOA 28c. Injury	4 L Nursing F	dome 5 Resider		pecify)
n O	nding ath. :: Afte e fun	cat		nth, Day, Year) injury	work'	? Yes 2 □ No	Zod. Describe nov	w injury occurred	
Division of	Atte er deg ectol by th	Certificate:	3 Suicide 6 Could not be 28e. Plac	e of Injury - At home, farm, stre	eet, factory, office				Rural Route Number,
2	Ital or Irs aft af Dir Ied in		Build	ing, etc. (Specify)			City or Town,	State)	
	To the Hospital or Attending Physiciam: The Norse after death. To the Funeral Director: After this certification properties of the funeral director, The funeral director.	Medical	29a. Certifier 1 Certifying Physician: To the 2 Medical Examiner: On the ba	sis of examination and/or invest	igation, in my opinio	 n. death occurred 	at the time, date and	blace, and due to the	ne cause(s) and manner stated
	ithin (ithin or the or		only one) 3 Certifying Nurse Practitione 29b. Signature and title of certifier	r: To the best of my knowledge,	death occurred at the	ne time, date and p	place, and due to the	cause(s) and manne	er as stated.
	10+1			Russia	DAG /	0000	28	d. Date signed (Mo	19 2012
	V = .	ł	30. Name and address of person who completed cau	se of death (Item 23a) (Type P	() () ((rint)	20+++	- 11	ICHEAN DES	1-1 4012
			100 0	ince Philip D	rive OI	ney 1	laylan	1 200/3	2_
	State	-	31. Date filed (Month, Day, Year) \$2.1	Registrar's Signature	eld)	((
	Registra	r	NOV 2 7 2012 12-1	was as sugar					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 40526 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ $\overset{\text{Day}}{2}1_20\overset{\text{Year}}{12}$ 12:37 A M <u>Carol Jean Wayson</u> November Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Annapolis Anne Arundel Medical Center Anne Arundel **Funeral** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Days Hours 1 □ M 2 💢 F (Month, Day, Year) 09-27-1953 California **Director** 219-64-8407 59 Usual Residence of Decedent of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No MD Anne Arundel Lothian 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6235 Southern Maryland Boulevard 20711 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ⚠ No
If Yes, Give Black. White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced Specify: White Year or Dates permit. Page 1 and 2 should be filed within 72 hours popartment of health and Mental Hyglene. Important. If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Insurance</u> Agent and Broker 12 Commercial Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ Charles Russell Rayburn Ruth Elizabeth Behe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard A. Wayson, Spouse 6235 Southern MD Boulevard, Lothian, MD 20711 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory 11/27/12 Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consumence of): Examiner Herastatee concer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months
1 Yes 2 No Pregnant at time of death ed by the detached g Unknown Unknown been signed by should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? After this certificate 1 Yes 2 No Yes 2 - No Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital Other: 1 Tes 2 400 မှ 1 Unpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural
Accident
Suicide (Month, Day, Year) injury work? 5 Pending neral Director: / I filled in by the f Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

dRW 10

Registrar

Udu

Date filed (Month, Day,

ar

Medical

32. Registra s Signature

30. Name and address of person/who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene 40527 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November T6. 2012 Eleanor Gertrude Ward 8:40 P.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Calvert Calvert County Nursing Center Prince Frederick If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Hours **Director** 218-30-3426 1 □ M 2 🏋 F 90 Yrs. 09/27/1922 Maryland 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f sl edical Examiner must be notified 1 ☐ Yes 2 🕅 No MD Calvert. Owings 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 20736 U.S.A. 1743 John C. Ward Road permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu, once. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Armed Forces 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 U.S. Postal Service postmaster Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Trott Ward Annie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol L. Ward, niece 1819 John C. Ward Road, Owings, MD 20736 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Friendship Cemetery | 11/21/2012 | Friendship, MD Some ure of Funeral Service Licens 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Pinal Physician/ Atheroscleratio disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Corchioves when disease typertensive Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director; After this certificate has been signed by the attending physician and Cause (Disease or injury burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 the use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Year 5 Other (specify) 4 Pregnant 9 Unknown Pregnant at time of death 1 Yes 2 g Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Sepsi's 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 风 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No End stage Demention 24a. Was an 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 1 Natural 28d. Describe how injury occurred iniury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one) 29d. Date signed (Month, Day, Year) 50653 C. SURANA GYAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) dew 8 5551. Devile Road Deane 32. Registra s Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	for State of IVIA State Registrar	ryland / Dep <i>Cel</i>	artment of H rtificate of D			eg. No. 201	2 40528	
F	Physicia	n/	1. Decedent's Name (First, Middle, Last)				2. Date of Deat		3. Time of Death 5:50 a M	
	Medic	al	Mildred D. Wilson 4a. Facility Name (if not institution, give street and number)		4b City Town or	Location of Death	11	4c. County of		
	Examin	er	Calvert County Nursing Center	er	1	Frederic	k	Calv		
	Funeral		5. Social Security Number 6. Sex 7. Age ((In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		. Birthplace (State or Foreign Country)	
	Director		214-48-7487 1 □ M 2 🗓 F Usual Residence of Decedent	86 Yrs.			02/14/1		NC	
	and show lat	or		10c. City, Town or Lo	ocation				10d. Inside City Limits	
	Maryl 28a-f otifiec	Director	FL Sumter	The Villa	ages				1 🗌 Yes 2 🕱 No	
	th the		10e. Street and Number		10f. Zip Code		1	10g. Citizen of Wha		
	ms 2;	Funeral	1217 Carvello Drive 11. Marital Status 12. Was Decedent Ev.	er in IIS 13	32162	spanic Origin? (Spe	cify Yes or No-	United S	American Indian,	
9	er dez or ite	by F	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕱 N	lo.	Was Decedent of His If Yes, specify Cubar		Rican, etc.)		White, etc.	
00 00 00 00 00 00 00 00 00 00 00 00 00	urs aft ural", al Exa	ted	3 ☒ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.		1 Yes 2 🔀 No	Specify:		Specify:	White	
2-(s filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa kind of work done d OO NOT use retired)	ation <i>uring most of worki</i> i	ng	16b. Kind of Busin Board of	ess/Industry Education	
212	vithin giene. sr thau		Elementary/Secondary (0-12) College (1-4 or 5+))	feteria Wo	orker			Georges County	
<u>g</u>	be filed v ental Hyg ked othe ic event,	Be c	17. Father's Name (First, Middle, Last)			18. Mother's Name		Maiden Surname)		
<u> </u>	ould be fil id Mental marked i matic ev	₽	Irby Thompson	-1-		011ie K				
Maryland 21215-0036	2 should ith and Me 27 is mar traumati		19a. Informant's Name/Relationship (Type, Print) Walter T. Wilson / Son		ing Address (Street a Amber Lane				, Zip Code)	
	and Heal em		20a. Method of Disposition	20b. Place of Dispo	osition (Name of			20c. Location - Cit	ty or Town, State	
E O	. 0		1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Lee Crem	matory or other place latory	11/28/	2012	Clinton,	MD	
Baltimore,	permit. Page Department Important: Il any injury or		21. Signature of Funeral Service Licensee Amanda M Ergler.		2. Name and Addres		Funeral	1 Home Ca	lvert, P.A.	
			23a. Part 1. Enter the disease, or complications that caused t						Approximate	
-1	Physician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	cleantie	Cardio	Wasudan	dilan	Co	Interval Between Onset and Death	
	Medical Examiner		resulting in death) a. Due to (or as a of	Clenntic consequence of): tensive	/ /-	30000111				
		ner	if any, leading to immediate Dul to (or as a	consequence of):	(ard)o	VCI3 WIR	07 115	C05-C		
	uted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c						2	
	cate be executed physician and s the burial-transit		resulting in death) Last Due to (or as a	consequence of):						
760	cate by physic s the b	edical	d							
89	certificanding use as	m/m	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of	f pregnancy	Tectonic pregnanc	v		23d. Date of	of delivery	
Bo	e death the atte	Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown		Other (specify)	у		Month	Day Year	
Ö	hat the ed by detac		Part II. Other significant conditions contributing to death but	t not resulting in the	underlying cause giv	en in Part I.	23e. Did tot	bacco use contribu	ite to the cause of death?	
<u>S</u>	uires t in sign uld be	ed b	Stroke due to ceret	oral thro	mhosis		1 🗆 Yı	es 2 🗆 No 3	Probably 4X Unknown	
Division of Vital Records, P.O. Box 68. To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	aw rec as bee 2 sho	Completed by	Hyperlipidemia.				24a. Was a	sy prio	re autopsy findings available or to completion of cause of	
	The la	Con					1 🗆 Yes		th? Yes 2 No	
ta	ician; certific rector,	Be	25. Was case referred to medical examiner? 1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No} \) Hospital:		Othe	ace of Death (Check				
) 	y Phys er this eral di	e: To	27. Manner of Death 28a. Date of injury		nt 3 □ DOA 28c. Injury	4 Nursing Ho		ence 6 Other (Some of the control of	Specify)	
ouo	anding aath. or: Afte he fun	ficat	1 Natural 5 ☐ Pending (Month, Day, 2 ☐ Accident Investigation	Year) injury	M 1 🗆	? Yes 2 \Bo				
INISI	l or Atter after de Directo	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury building, etc.	y - At home, farm, sti (Specify)				(Street and Number or Rural Route Number, own, State)		
۵	Hospita 24 hours Funeral itely filled	edical	29a. Certifier 1 Certifying Physician: To the best of m (Check 2 Medical Examiner: On the basis of examiner:	amination and/or inves	stigation, in my opinio	n, death occurred at	the time, date an	d place, and due to	the cause(s) and manner stated.	
	fo the vithin to the comple	Σ	only one) 3 Certifying Nurse Practitioner: To the 29b. Signature and title of certifier	best of my knowledge	e, death occurred at the 29c. License			e cause(s) and man 29d. Date signed (N		
			Dayan .c. Sw	ance.		5653	1	11-26	-2012	
98	n 11		30. Name and address of person who completed cause of dea 5851 - D-Lule Chwol		Print) GYA	N.C. SI Deale	NANI	2075/		
VY	Stat Registra		31. Date filed (Month, Day, Year) 32. Registre NOV 2 7 2012		Sares		.,,,,,,,			
			1	7.00	/ -					

State of Maryland / Department of Health and Mental Hygienes Reg. No. 40529 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Harold November 14, 2012 7:20 Mercer Young PM Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Sunrise of Montgomery Village Montgomery Village Montgomery Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Hours 233-40-8520 **Director** 1 M 2 □ F 84 Jan. 1, 1928 West Virginia Usual Residence of Decedent or 28a-f show notified at with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Montgomery Gaithersburg 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? be must be Funeral 9508 Emory Grove Road 20877 United States "natural", or items be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 N Yes 2 No 19
If Yes, Give 10 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc 1946-Ď 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 1947 3 XWidowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Claim Inspector Insurance Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Samuel Hershel Young Leta Paul Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9508 Emory Grove Road, Gaithersburg, MD 20877 Kathleen Y. Foley (Daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Cemetery, crematory or other place)
R.A. Ferris
and Company 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State November 19 W. Chester, PA 4 Donation 5 Other (Specify) 2012 Signature of Funer Survice Ucenses 22. Name and Address of Facility DeVol Funeral Home, Man the M00689 10 E. Deer Park Drive, Gaithersburg, MD 20877 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician Aspiration Pneumonia disease or condition hours Medical resulting in death) Due to (or as a consequence of): **Examiner** Chronic Obstructive Pulmonary Disease vears Sequentially list conditions, Due to (or as a consequence oi). if any, leading to manufalate cause. Enter Underlying Cause (Disease or injury that initiated events transit Dementia vears Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Box 68760 the as IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Month Pregnant at time of death Day Year 1 Yes 2 No 9 Unknown should be detached 9 Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Depression 1 Yes 2 No 3 X Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform within 24 hours after death.
To the Funeral Director, After this certificate 2 No Yes 2 X No 1 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Assisted Living 2 🔀 No Other: 4 Nursing Home 5 Residence 6 X Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 X Natural injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number. City or Town, State) Hospital Medical 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D31391 all November 15, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suhair H. Abulfarag, M.D., 604 S. Frederick Avenue, #413, Gaithersburg, MD 20877 31. Date filed (*Month, Day, Year*) NOV 2 0 2012 37. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1tem 2 per doc 9935 1-8-13 vt. State of Maryland / Department of Health and Mental Hygiene

Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **19** Day 11-20-2012 **Physician** 3:50 AN Fitzgerald Yammie /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ivy Hall Geriatric Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6-25-1926 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. Trinidad 1 X M 2 ☐ F 86 213-62-3499 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State or 28a-f show or than "natural", or items 23a or 28a-f show the Modical Examiner must be notified at Md. Baltimore 1 XYes 2 No Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8864 Pennsbury Pl. 21237 Trinidad withIn 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black Specify: Completed by 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Welding Fabrication metal Fabrication Welder 12 other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Leonard Yammie Josephine Jackson Pages 1 and 2 should ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a 21237 8864 Pennsbury Pl, Baltmore,Maryland Dexter C. Yammie- Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 6 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or QDG8. * 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Park Crematory 11/23/12 riverdale park/Md. 22. Name and Address of Facility 411kennedy st.n.w.
Universal Mortuary Inc., Washington, D.C. 20011 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e mez tig **Physician** /Medical Due to (or as a consequence of): Examiner THOIN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed burial ia that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria menic Physician/Medicai the as IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Dav Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, should be c δ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 XNo certificate has birector, page 2 s 2 🛛 No 1 ☐ Yes Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: ၉ 1 ☐ Yes 2 🖔 No 1 🗌 Inpatient Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) After the 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification; Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide ō Hospital 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier th (Item 23a) (Type. Marge and address of person who complete Print) MD 21221 1 timore KWUMa 31. Date filed (Month, Day, Year) 32. Registrar's Signature... State Registrar NOV 26 2012

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death December Day, 2012 2:10 P Physician/ Caroline Elizabeth Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Columbia Gilchrist Hospice If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Funeral 219-32-6452 77 Director 1 □ M 2 🖾 F October 17,19\$5 Maryland Yrs. then "neturel", or items 23s or 28s-f shov the Medical Examiner must be notified at 10d. Inside City Limits 10h County 10c. City. Town or Location 10a, State within 72 hours efter death with the Meryland Director 1 Yes 2 No Catonsville Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funera USA 21228 207 S. Rolling Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 1 Yes 2 No Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) end Mentei Hygiene. Is merked other then Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) .. Pege 1 and 2 should be fill tment of Heelth end Mentel tent: If Item 27 is merked o Catherine M. Bader Clark, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3910 Commander Drive, Hyattsville, MD 20782 John C. Alder- SON Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 A Burial 2 Cremation 3 Removal from State permit. Pege Depertment of Importent: If eny Injury or once, ŏ Marriottsville, MD Crestlawn Mem. Gardens12/13/2012 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Ave., Catonsville, MD 21228 21. Signature of Funeral/Service Licenses MO12) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final OUNTAM CAMCER Pnysician Metastatic disease or condition Medical resulting in death) Due to (or as a consequence of): [′]Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): ig physicien end es the buriei-trensit The lew requires thet the deeth certificete be executed Due to (or as a consequence of): Physician/Medical Box 68760 for use es IF FEMALE: 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death esn n 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day ed by the e 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Gastro intestinal Bleeding, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificete hes I rei director, pege 2 : autonsy 1 ☐ Yes 2 ☐ No Yes or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) B Other: 4 Nursing Home 5 Residence 6 Other (Specify) pice 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 IDOA မှ To the Hospitel or Attending Phys within 24 hours after deeth.

To the Funerel Director: After this a compietely filled in by the funerel di 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 ☐ Natural 2 ☐ Accident 5 Pending Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier December 10,2012

Registrar

DHMH 17 Rev 06-2011

State

6701

N. Charles St.

30. Name and address of person who completed cause of death (Mem 23a) (Type, Print)

GBMC

32. Registrar's Signature

151

4 2012

31. Date filed (Month, Day, Year)

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Baltimore, permit. Pages 1 a	ortant		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee Victor P. Do	_					
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100	M		(andokeell)		O.C.N	I.E.		December 2	, 2012
10	Aust		 Name and address of person who completed cause of death (Item Laron Locke MD. Assistant Medical Examiner 		nore Street,	Baltimore, M	1D 21223		
F	St Regist	ate rar	31. Date filed (Month, Day, Year) 32. Regigrar's Signature of the Signatur	ure			_		

Physician Provided Examiner Provided Examiner December Service Ser	any ity Limits 2 \(\sum \text{No} \)
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and manner stated. 29c. License number 29d. Date signed (Month, Day, Year	
O.C.M.E. December 9, 2012	
30. Name and address of person who completed sause of death (Item 23a) Mary G. Ripple MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
State 31. Date segment, pay, red 12 32. Registrar's signature and segment segments.	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEMBER Day 10, Year 2012 JEROME JOHN ANDREASIK.SR Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner TOWSON If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days (Month, Day, Year) Hours Country) 213-28-8622 81 1 M 2 D F Director 1-13-1931 MARYLAND ir than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🕱 No MD. BALTO. NOTTINGHAM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 32 BELHAVEN DRIVE 21236 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, et 1 Never Married 2 Married þ WHITE If Yes, Give Year or Dates 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) MEAT CUTTER **ESKAY** Be injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) FELIX ANDREASIK LOUISE OLSZEWSKI and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st.
Department of Health an
Important: If Item 27 is any Injury or any **SPOUSE** JEANNETTE ANDREASIK 32 BELHAVEN DRIVE NOTTINGHAM, MD. 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-14.2012 PARKWOOD PARKVILLE. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC. 6415 BELAIR ROAD BALTIMORE, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Éxaminer 2 DAYS Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlal-transit Due to (or as a consequence of) resulting in death) Last Physiclan/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform Yes 2 No 1 Yes 2 2.No 25. Was case referred to medical B B 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 🗶 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Centrying Nurse Fractification To place to the cause (s) and manner stated 3 centrying Nurse Fractification To place to the cause (s) and manner as stated (Check unity one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE TOWSON, MD 21204 State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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James Dennis Bui	1	- For State	State of Maryl		oartment e <i>rtificat</i> e			Mental H		201 g. No.	2 40535
Physician Medical Examine	1	James	^{ddle,Last)} Denn	is	Bur	cow,	III		Date of Death Month December	Day Year	3. Time of Death 0056 hrs
	ľ	a. Facility Name (if not institu Bowie Health Cente		umber)		4b. City, Bow		ocation of Death	1	4c. County of De	
Funeral Director	1	5. Social Security Number 506-66-3273	6. Sex		s. last birthday)	If Und	der 1 Year ths Days	If Under 24Hrs Hours Min	. 1		Birthplace (State or eign Gent Paska
	Ŀ	Jsual Residence of Decedent			,,,				Aug. 3	1,1949	
ow any		10a. State 10b. Count MD Prince	^{ty} ce George '		ity, Town or Lo	Bowi.	e				10d. Inside City Limits 1 Yes 2 No
aryland 8a-f sh at once	Director	10e. Street and Number		3			p Code		10	g. Citizen of What C	-
ith the Maryland 22a or 28a-f show ootified at once.		13717 Urbana					207			United S	
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be outfred at one.		11. Marital Status 1 Never Married 2 3 Widowed 4 X [ecedent Ever in Forces? 2 No		f Yes, spec		Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Am White, etc	nerican Indian, Black, White
urs afte	<u>6</u>	15. Decedent's Education (S	or Dates:) 16a, Dece	dent's Usua	I Occupation	on (Give kind of		16b. Kind of Busines	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death wi Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items joiury or other traumatic event, the Medical Examineer must be	ompleted	Elementary/Secondary (0-1	2) College	(1-4 or 5+)			loyed	DO NOT use ret	ired)	Pawn Bro	ker
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	2 8 8	17. Father's Name (First, Midd	_{dle, Last)} Dennis	Ві	urrow	(J ₁		8.Mother's Nam Avis	e (First, Middle, N	Maiden Surname)	Unknown)
212 hould be and Ment is mark		19a. Informant's Name/Relation	onship (Type, Print)		19b. Ma	ling Addres	ss (Street			nber, City or Town, St	
and 2 sho lealth and tem 27 is		Rachel Marie		20	b. Place of Dis	osition (Na	ame of cem		Date Date	20c. Location - City	or Town, State
MOFC Pages 1 ent of F unt: If i	- 1	1 Burial 2 T Cremat 4 Donation 5 Other		from State (crematory or Chesape	ake C	_{e)} remat	ory 12/	14/2012	Beltsvi	11e, MD
Baltimore, permit. Pages 1 a Department of He Important: If its iojury or other to		21. Signature of Funeral Servi		M003	82 2	Rapp ^{an} 933 G	funer ist A	afacilitynd ve., Si	Crematic lver Spr	on Service	s 20910
Physician	┪	23a. Part I. Enter the disease, failure, List only one cau	, or complications that use on each line.	caused the dea	ath. Do not ent	er the mode	of dying, s	such as cardiac	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
Examiner	1	Immediate Cause (Final disea or condition resulting in death		sive Atheros a consequenc		rdiovaso	ular Dise	ease			Death
	ا ا	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequenc	e of):						+
	Examiner	cause. Enter Underlying Cau (Disease or injury that initiate	ed c.	a consequenc							
		events resulting in death) La	d								
D. be exe	edical	UNPENDED	AMENDED		rognanov					23d. Date of deli	Werv
Division of Vital Records, P.O. Box 68760 To the Hospital or Atteoding Physician: The law requires that the death certificate I within 24 hours after death. To the Fuoeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the bin.	Physician/M	IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9	1 Live	s, outcome of page birth gnant at time of known	2 🗌	Fetal deat	_	Ectopic pregr	nancy	Month	Day Year
P.O. Be ires that the de signed by the ibe detached f		Part II. Other significant con	nditions contributing	to death but n	ot resulting in t	ne underlyi	ng cause g	iven in Part I.			e to the cause of death?
rds, P. requires the been signe thould be de	ted by	Hepatitis C; Chron	ic Alcoholism						1 Yes		Probably 4 Unknown a autopsy findings available
of Vital Records, ag Physician: The law require the this certificate has been sinneral director, page 2 should be	Completed								autop perfo 1 ✓ Yes	rmed? deatl	
tal Rec	မ္မ	25. Was case referred to med						of Death (Check	conly one)		1.00 2 1.0
f Vita		examiner? 1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1	Inpatient 2	✓ ER/Outpat			Other Nurs	ing Home 5	Residence 6 0	ther:
ion of teoding Pheath. to After the funeral	흲	1 Natural 5 P	Pending (Mo	nth, Day,Year)	200. 11110	o. Injury		res 2 No	254. 556525		
Division Bospital or Atteodi 24 hours after death. Fuoeral Director: /	Certification:	3 Suicide 6 C	Could not be determined (Special	ace of Injury - A	At home, farm,	street, facto	ory, office b	uilding, etc.	28f. Location (or Town, S		r Rural Route Number, City
To the Hospity within 24 hours To the Fuoers completely fill	Medical Ce	4 Homicide 29a. Certifier 1 Certifying one) 2 Medical E	g Physician: To the b Examiner: On the bas	pest of my know is of examination	vledge, death o	ccurred at t	the time, da	ate end place, ar	nd due to the caus I at the time, date	se(s) and manner as and place, and due t	stated. to the cause(s)
To To To com	Mec	29b. Signature and title of cer	and manne				29c. Licens			29d. Date signed	(Month, Day, Year)
		aness					0.0.1	M.E.		December 2,	2012
\		30. Name and address of per Ana Rubio M.D., Ph		ause of death (I t Medical E		900 W. E	Baltimore	Street, Balt	imore, MD 2	1223	
Sta Registi		31. Date filed (Month, Day, Ye		Registrar's Sig	nature	Kad					

12-09398	
Amanda Barrett	

a Barrett		State of Maryland / Department of Health and Mental Hygie	ene	2012	40536
		I- For State Certificate of Death	Reg. No.	2012	. 40000
Physicia	an/	1. Decedent's Name (First Middle Last) 2. De	ate of Death		3. Time of Death
al Exami			lonth Day ecember 10, 20		1007 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 7012 Park Heights Ave Apt A4 Baltimore	4c. C	county of Death	
F			Date of Birth (MM/DD	D/YYYYY 9. Birti	nplace (State or
Funeral Director		Months Days Hours Min.	·	Foreign	1
		982-72-0295 1 M 2 F 7.1 - Yrs. (07-22-19	41	^{Intry)} Jamaica
any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
and show	×	MD Baltimore			1 Yes 2 No
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 10f. Zio Code	10g. Citize	n of What Coun	try?
the N		7012 Park Heights Ave. Apt. A4 21215		amaica	
h with	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify In Yes, specify Cuban, Mexican, Puerto Rica		 Race - Americ White, etc. 	can Indian, Black,
or it	필	1 Yes 2 x No		if:: D1	ale
rs afte	ğ	3 Widowed 4 Divorced If Yes, Give Year T I Yes 2 X No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work of the complete) 16a. Decedent's Usual Occupation (Give kind of work of the complete)		pecify: Bla	
2 hou	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+)			•
thin 7 ne. than ledica	n de	12th Seamstress	Se	lf Emp	loyed
ed wi	Co	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)	st, Middle, Maiden St	urname)	
be fill ental F urked vent,	Be	Earnest Green Addala	Eddly		
hould nd Me is ms	To	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural			
adth a		Jack E. Thompson, son 815 E. Coldspring I. 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Family Plot Family Plot	n Baltir	nore M	d 21212 Town State
es la of He If ita		1 Burial 2 Cremation 3 Removal from State Crematory or other place)	Mai	coon To	n Town
Pag tment tant:		4 Donation 5 Other Specify:		ntego :	
Depar Impor			Ba	altimo	re Md 212
ysician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or res	piratory arrest, shock	eister k, or heart	StownRd Approximate Interval
Medical		failure. List only one cause on each line.			Between Onset and Death
kaminer		Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):			-
		Sequentially list conditions, b.			
	iner	if any, leading to immediate Cause. Enter Underlying Cause			
	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of):			
executed an and al - transit	al E	d			
9 2 4	dical	▼ UNPENDED ▼ AMENDED#1 as noted, 23a, 27, per me, g935 1-9	9-13 sm		
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		Date of delivery	y Day Year
ending use as	ciar	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	"	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, ay
e death the att	ysi	1 Yes 2 V No 9 Unknown 9 Unknown			
that the deat ned by the at detached for	y PI	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			the cause of death?
ires that signed b	d by				oably 4 ✔ Unknown
v requ s been should	Completed		24a. Was an autopsy	prior to d	topsy findings available completion of cause of
The lavicate hapage 2	臣		performed? 1 ✓ Yes 2 No	death? 1 ✓ Ye	es 2 No
cian: The law requir certificate has been sector, page 2 should	Be	25. Was case referred to medical 26.Place of Death (Check only	one)		
hysician: this certifi al director,	10 B	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 1 Nursing Ho	ome 5 Residen	ce 6 🗹 Othe	: Scene
ding Phy 1. After th funeral		(Month, Day, Year)	f. Describe how injur	y occurred	
Attendi er death. rector: by the f	ag	2 Accident Investigation			
or A after of Direct	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f.	 Location (Street and or Town, State) 	d Number or Ru	ral Route Number, City
To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the f	පි	4 Homicide determined (Specify)			
n 24 h		29a. Certifier 1 Check only (Check only 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the	to the cause(s) and time, date and place	manner as states, and due to the	ed. e cause(s)
omp	Medical	and manner stated.		ate signed (Mo	
C > C > I	≥	29b. Signature and title of certifier 29c. License number			
()) OCME OCHAE	Dece	emperii	J12
ark.		Theodo We King JR. M. D. O.C.M.E. OGME	Dece	ember 11, 2	J12
yer de		30. Name and address of person who completed Euse of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltin	***		J12

Registrar

12-09270								
Mary P Bullock								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certificate o	of Death		Reg. No	201	2 4053		
Physicia Il Exami	an/ ner	Decedent's Name (First, Middle,Last) MARY P. BULLOCK			2. Date of Month Dece	of Death Day mber 5, 2	Year 012	3. Time of Death 1730 hrs		
		Facility Name (if not institution, give street and number) Johns Hopkins Hospital		4b. City, Town, or Location Baltimore			c. County of Death			
Funeral Director		213-32-9097 1 M 2 NF	In yrs. last birthday)	If Under 1 Year If Und Months Days Hour	Min	of Birth (MM 27–193	/DD/YYYY) 9. Bir Foreig Co			
varyland 28a-f show any d at once.	J.	Usual Residence of Decedent 10a. State	Oc. City, Town or Loca					10d. Inside City Limits 1 X Yes 2 No		
a or 28a-f	Director	10e. Street and Number 7363 VINE ST. UNIT A		10f. Zip Code 21201		-	izen of What Cou	ntry?		
n "natural", or items 23a or 28a-f sho la Examiner must be notified at once	eted by Funeral	3 Widowed 4 Divorced IT Yes 2 La No specify: Spe								
Hygiene d other than	Completed	-120- 17. Father's Name (First, Middle, Last) JAMES H. BULLOCK	NURS	18.Mothe	r's Name (First, M ULINE HE	iddle, Maider		RE		
h and Menta 27 is marke ımatic event	To Be	19a. Informant's Name/Relationship (Type, Print) LONZELLA BROWN (DAUGHTER)		ng Address (Street and Nur 1 ASHLAND AVE	mber or Rural Rou	te Number, (City or Town, State			
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner		20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	KING ME	MORIAL PARK	Date 12-12-20	12 BA		Town, State MARYLAND		
Sician		21. Signatu Tuneral Service Licensee ON A HAN 23a. Part/I Enter the disease, or complications that caused the	_ 1	721-27 N. MON	ROE ST.	BALTIN	MAE, MAE	RYLAND 21217 Approximate Interval		
l ical aminer		failure, List only one cause on each line.	e Atheros	clerotic Card				Between Onset and Death		
sit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of the consequen								
physician and the burial - transit	Medical E	■ d	7,per me,	g935 1-9-13 s	m					
ned by the attending phys detached for use as the b										
, ⇒ ŏ	by		ut not resulting in the	underlying cause given in P		_		the cause of death?		
onld s	lete				[Was an autopsy performed?	pnor to death?	utopsy findings available completion of cause of		
icate has b	Comp				_			2 110		
his certificate has b director, page 2 sh	o Be Completed	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient	2 ✔ ER/Outpatie	26.Place of Death	_	5 Resid	ence 6 Othe			
tections and second of the following the following the following the following the funeral director, page 2 should be detach the funeral director, page 2 should be detach.	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 27. Manner of Death 1 X Natural 5 Pending		nt 3 DOA Other	(Check only one) Nursing Home k? 28d. Dec		ence 6 Othe			
	Certification: To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28a. Certifier	y - At home, farm, str	nt 3 DOA Other a finjury at Wor 1 Yes 2 reet, factory, office building, e	(Check only one) Nursing Home k? 28d. Det No 28f. Loc or T	ation (Street	jury occurred and Number or Ru	ural Route Number, City		
	Certification: To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 29a Certifier (Check only one) 2 Medical Examiner: On the basis of examination of the control of the cont	y - At home, farm, str	nt 3 DOA Other a finjury at Wor 1 Yes 2 reet, factory, office building, ecurred at the time, date and p	(Check only one) Nursing Home R? 28d. Det No 28f. Loc or T	ation (Street own, State)	jury occurred and Number or Ru	ural Route Number, City		
o to the doption or Automong Proyectar: The faw ro within 24 hours after death. To the Funeral Director: After this certificate has be completely filled in by the funeral director, page 2 she	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 29a Certifier 1 Certifying Physician: To the best of my king the control of the county of the coun	y - At home, farm, str	nt 3 DOA Other a finjury at Wor 1 Yes 2 reet, factory, office building, ecurred at the time, date and p	Nursing Home R? 28d. Des No 28f. Loc or T ace, and due to the courred at the time	ation (Street cown, State) ne cause(s) a e, date and p	jury occurred and Number or Ru	ted. ne cause(s) onth, Day, Year)		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per the 934 12-21-12 yr. State of Maryland / Department of Health and Mental Hygiene For State Registrar 40538 Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ewton 6:00 AM)ecember 12,2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 0+ Washington 8. Date of Birth Social Security Number 6 Sex _{Year}1944 7. Age (In yrs. last birthday 9. Birthplace (State of Foreign **Funeral** 250-64-1 M M 2 D F Months 038 August Director ms 23a or 28a-f show must be notified at 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 No Washi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 744 oa items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian. Examiner Armed Forces Black, White, etc. ō ģ 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Completed I 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Arlington Co. Government Maintenance h and Mental Hygien 7 is marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ಲ rewton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brewton 10 t Department of Health Important: If item 27 any injury or other tr once. Fort Washineston Koad 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1- Burial 2 ☐ Cremation 3 ☐ Removal from State 18 Pleasant Valley Memorial tark 4 ☐ Donation 5 ☐ Other (Specify) Annanda le, Vicamia 21. Signature of Funeral Service Licensee Service Funeral Robert B Bak linaton 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final toors Physicians on disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and signed by the attending physician and deed be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Fetopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Year 5 Other (specify) Day Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 2 🗌 No Yes 2 No 25. Was case referred to medica completed filled in by the funeral director, Medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital 2 8 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, 10105084 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George Mason Dr. #490 eanine MD 16 31. Date filed (Month. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#25perME, G934, 12/14/2012 WS
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2012 40539 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Nov. 25, Year Physician/ 2012 Marv Byrnes Jane 10:15 A™ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore Good Samaritan Nursing Home | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Octoor 24, Year 928 Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 M 2 X F Marvland 84 Director 220-20-5585 Usual Residence of Decedent show or 28a-f shov notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County with the Maryland Director Maryland N/A Baltimore 1 X Yes 2 □ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ò permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a ray injury or other traumatic event, the Medical Examiner must be a USA Funeral 417 Cornwall Street 21224 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🛛 No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: If Yes, Give 3 Widowed 4 X Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Telephone Company Telephone Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ruth Mary McDonald ಲ Clayton Joseph Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21224 417 Cornwall Street Baltimore MD James M. Byrnes/Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Most Holy Redeemer 20a. Method of Disposition 20c. Location - City or Town, State Date 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State 11/29/12 Baltimore MD 4 Donation 5 Other (Specify) 21. Sign thre of Funeral Service Ligense Leonard J. Ruck, Inc. 5305 Harford Road Baltimore MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Intra Cranial Henorahase Immediate Cause (Final disease or condition Physician/ Medical resulting in death) EXAMINER Due to (or as a consequence of) Examiner STION APPROVED BY Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Examine Due to (or as a consequence of) aftending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last CFRT1 Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 been signed by the aftending p should be detached for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Pregnant at time of death a | Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 s autopsy performe Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Physical within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dil After this 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident
Suicide Investigation 6
Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 📝 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b, Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) . L. /S. Kun 11) November 25 2012 058570 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 boch Rover Blud L. Baker MI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 2 7 2012 Barkel Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year 2012 7:02 Louis Carl Bernstein A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring 8D9 Whittington Terrace 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Hours 220-70-8861 Director 1 **X** M 2 □ F 54 Yrs. 3-24-1958 Washington, DC Usual Residence of Decede ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Directo Silver Spring MD Montapmerv 1 ¥ Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 20901 809 Whittington Terrace Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify Specify: Completed 3 Widowed 4 Divorced White Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hyglene. Elementary/Secondary (0-12) College (1-4 or 5+) Technology Computer Technician Be permit. Pege 1 and 2 should be filed Department of Heelth and Mental Hy Important: If Item 27 is marked oth any injury or other treumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Loraine Goldstein Samuel Bernstein 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8529 Mountain Holly Drive, Pikesville, Maryland 21208 Leslie Seff - Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State King David Mem. Gardens 12-14-2012 Falls Church, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapel Edward Sagel 1178 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Years Onset and Death Immediate Cause (Final Physician/ End Stage Renal Disease Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physiclen: The law requires that the death certificate be executed 24 hours after death.
Funerel Director: After this certificate has been signed by the ettending physician and the ettending physician and shed for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐ Yes 2 ☐ No deteched 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Diabetes Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown After this certificate has been significate has been significated and funeral director, pege 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? ☐ Yes 2 🗶 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 AResidence 6 Other (Specify) 2 🗶 No မှ 1 🔲 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA within 24 hours after death.

To the Funerel Director: After this completely filled in by the funeral of 28b. Time of Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending injury work?
1 Yes М 2 🗌 No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 💹 Certifying Physi⊑ian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Deel as 12-11-2012 D19192 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barry Hecht, MD - 3941 Ferrara Drive, Wheaton, Maryland 20906

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Mon# ⊕at, Year) ₩

brinstein,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Occember 4, Day 2012 Physician/ Clare Skolnick Brown A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Apt B406 Rockville 14411 Traville Garden Circle, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex **Funeral** (Month, Day, Year) Days 134-14-6524 89 Director 1 □ M 2 🖺 F May 30, 1923 New Jersey orent: if item 27 is marked other then "neturel", or items 23e or 28e-f show Injury or other treumetic event, the Madical Examiner must be notified at 10d. Inside City Limits 10b. Count 10c. City, Town or Location flled within 72 hours efter death with the Maryland Director 1 Yes 2 No Montgomery Rockville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States apt B406 20850 14411 Traville: Garden Circle 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Black, White, etc. 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business/Industry permit. Pege 1 and 2 should be filed within 72 h
Department of Health and Mentel Hygiene.
Important: If Item 27 is marked other then "ne
any injury or other treumetic event, the Madic (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Dwn Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna (unknown) ഉ Harry Skolnick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12 Monterra Court, Rockville, MD 20850 Judi Greenberg Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery crematory or other place) 1 Burial 2 Cremation 3 Removal from State Olney, MD 12/6/2012 4 Donation 5 Other (Specify) 22. Name and Address of Facility Danzansky Goldberg Memorial Chapels Inc. 21. Signature of Funeral Service Licen Man 1170 Rockville Pike, Rockville, MO 20852 u 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Conqestive Heart Failure Physician, 1 week Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) use as the burlei-trens After this certificate hes been signed by the ettending physicien end if tuneral director, page 2 should be deteched for use as the burlel-trer Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) 25 Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Yes 2 ☐ No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 🗌 Pending 1 Natural

or Attending Physicien: The lew requires thet the death certificate be executed 24 hours after death.

Funerei Director: After this certifics letely filled in by the funeral director.

Certificate:

Medical

29a. Certifier

(Check

only one) 29b. Signature and title of certifie

Accident Investigation 6 Could not be 3 Suicide

3 🗆

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

105

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29d. Date signed (Month, Day, Year) D006789

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1776 Powder Mill Road, Silver Spring, MO 20903 Simon Sirbu, M.O.

State Registrar

completely

within 2 To the

31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40542 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 210 am Physician/ Medical December 2012 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Baltimore ocheam luture If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Social Security Number **Funeral** 220:36.5090 Director 1 □ M 2 💢 F Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10b. County Director 1 X yes 2 No Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 21215 US4 Funeral Ridgewood Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forceş? 1 ☐ Yes 2 ☒No If Yes, Give 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Back Specify: 3 ₩ Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Health Care NURSE NIA 12th grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name First, Middle, Last) ဥ Mar MOVYIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21133 19a. Informant's Name/Relationship (Type, Print) (Daughter) Randallstown MD 9707 Branchleigh Road Apt. Charlene Ann Brook 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition or other 12 18 2012 1 Burial 2 Cremation 3 Removal from State Windsor MilliMD King Park Cemetery 4 Donation 5 Other (Specify) Vaughn C. Greene Funeral Services 21. Signature of Funeral Service Licensee aughn Road Bandallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Pnysician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to infine late cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day Pregnant at time of death g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed 2 10 1 Tyes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other 2 1010 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death Certificate: injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending 2 Accident Investigation 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 0076

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 40543 Certificate of Death 's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 9:10 PM SNWN December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince Regional Hospital George's aurel dure 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Director **X** M 2 □ F 64 or 28a-f show 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director notified 1 🗌 Yes 2 🗷 No aure serges 10f. Zip Code 10g. Citizen of What Country? pe Funeral items 23a 20723 12. Wa Decedent Ever in U. S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 If Yes, Give Black, White, etc. ō þ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Completed 3 ₩idowed 4 ☐ Divorced "natural" Blac Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industr (Specify only highest grade completed) ary (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other that any injury or other traumatic event, the Nonce. Be 17. Father's Name (First, Middle, Last) LAK ပ of Health and Ments 9a. Informant's Name/Belationship (Typel Print)

Darlene Brown Da lardell 20b. Place of Disposition (Name of temeter), cremalogy or other place 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State umbral 4 Donation 5 Other (Specify) Signature of Funeral Strvice License 23a. Part 1. Enter the disease, or complications that shock, or head failure. List only one cause on each line disease, or complications that caused the death. Do not enter the mode of dying, Approximate Interval Between Onset and Death Physician/ Respiratory disease or condition resulting in death) idrd10-Medical Due to (or as a consequence of Examiner Myocardial Sequer tially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events or Attending Physician: The law requires that the death certificate be executed Diabetes and Due to (or as a consequence of resulting in death) Last the burial attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Pregnant at time of death 2 No the a g Unknown g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an after death.

Director: After this certificate has autopsy death? 1 ☐ Yes 2 ☐ No 1 Yes director, Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 은 1 Inpatient 2 X ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work?
1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) To the Hospital within 24 hours To the Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check Certifying Nurse Practitioner: To the best of my knowledge, de eath occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 00 4695 7300 Van Dusen Rdi completed cause of death (Item 23a) (Type, Print)

State Registrar Sid

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40544 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December Day 11 2012 Physician/ Nancy Bevan 03:38 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 201 N. Crain Highway Apt Glen Burnie Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Year Months Days Hours (Month, Day, Director 218-36-3870 Dec. 08 73 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho sitcal Examiner must be notified at Director 1 Yes 2 No Glen Burnie Anne Arundel Maryland 4 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21061 201 N. Crain Highway Apt. 3T 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than College (1-4 or 5+) Elementary/Secondary (0-12) Motor Vehicle Administration State of Maryland 12 permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Helen Guzick Russell Tucker C. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 137 Crosstie Dr., Stewartstown, PA 17363 Patricia L. Horner - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Metro Crematory, Inc. Dec. 14,2012 Baltimore, MD 21. Signature of Funeral Service 22. Name and Address of Facility Stallings Funeral Home, PA 3111 Mountain Rd., Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one fause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and the burial-trai Due to (or as a consequence of): resulting in death) Last eral Director: After this certificate has been signed by the attending physician filed in by the funeral director; page 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of D ath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 \square Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Funer

completely fil 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier December 11, 2012 D39505 an 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Markon 305 Hospital Dr. Glen Burnie, MD. 21061

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Bay, Year)

Physician		State of Maryland / Department of Health and Mental Hyd For State Amend line 1, per MD C938, 4-4-2013, GBY Certificate of Death	Reg	.No. 2012	2 405
	1/	I. Decedent's Name (First, Middle, Last)	Date of Death	110.	3. Time of Death
al Examine	"[Dallas Joseph Bendermeyer, Jr.	Month December		1100 hrs
}		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 800 N Fremont Ανε 822 Ν Fremont Δχερ Baltimore		4c. County of Death	
Funeral	4	022 N. Hemone Ave	B. Date of Birth	(MM/DD/YYYY) 9. Birti	nplace (State or
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Aaryland 28a-f show I at once.	គ្ន	WV Hampshire Shanks	······		1 Yes 2
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permit. Pages I ar Department of Hea Important: If ite injury or other tr		4 Donation 5 Other Specify: Final Journey Crematory 12/1.	5/2012	Woodbine,	Maryland
ermit. epartr nport	I	21. Inature of Funeral August 1990 ns 22. Name and Address of Facility Going Home Cremation MO1251 peverly L. Heckrotte,	Servi	ce P.O. Box	784
	÷	MO1251 peverly L. Heckrotte, A. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or re	P.A. (Clarksville	Approximate Int
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To the Hospital or Attending Physician: The law requires that the death certificate be exe within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician a completely filled in by the funeral director, page 2 should be detached for use as the burial Modical Contribution To Be Completed by Dhysician Modical	Certification: To Be Completed by	25. Was case referred to medical examiner? 1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 4 Homicide 28. Place of Injury 28b. Time of Injury 28c. Injury at Work? 28e. Place of Injury 28b. Time of Injury 28c. Injury at Work? 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and durand manner stated.	1 Yes 24a. Was ar autops; perform 1 Yes 2 y one) tome 5 R id. Describe ho ubject 1 Cohol if. Location (St or Town, Ste altimo) e to the cause he time, date an	2 No 3 Prob 24b. Were aut prior to co death? 1 Ye esidence 6 Other ow injury occurred took heroi reet and Number or Rui tte) 822 N · Free ce, MD · (s) and manner as state and place, and due to the	ably 4 Unknot lopsy findings avail ompletion of causes s 2 Not seen and rail Route Number, emont Ave add. a cause(s)

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AMEND TIEM 9 PER FH C934 120 Health and Mental Hygiene State of Maryland / Department of Health and Mental Hygiene Certificate of Death 40546 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December Physician/ Worth Kurt Bittle 8:40 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 709 Woodsyde Circle Bel Air Harford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) MARYLAND Director 219-52-1555 1X M 2 | F Aug. 12, 1946 Married permit. Page 1 and 2 should be filed within 72 hours after death with the Meryland Depertment of Health end Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23e or 28a-f show eny Injury or other treumatic event, the Marked Examiner must be marked at once. Once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **USA** 21014 709 Woodsyde Circle 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 XMarried ģ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Art Educator Public Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Esther Louise Lambillotte Kyle Waters Bittle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 709 Woodsyde Circle, Bel Air, Maryland 21014 Susanne C. Bittle / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Commation 3 Removal from State 12-14-2012 4 Donation 5 Other (Specify) Bel Air, Maryland Rose Hill Svcs, LLC 21. Signatury Fuperal Service Licens 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatic mostate disease or condition resulting in death) 4 Medical Due to (or as a consequend of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami physiclan and s the burial-transit To the Hospital or Attending Physician: The lew requires that the deeth certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 % Physician/Medical IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day 1 Yes 2 9 Unknown 2 No g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🗹 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical VC'Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number D53186 December 11,2017 30. Name and actiress of person who completed cause of death (Item 23a) (Type, Print) Notickon Are ste C Bel air mis 2014 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40548 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Wallace Brockwell, Jr. James Dec. 8:29 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 12741 Cunninghill Cove Road Middle River Baltimore Co. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral (Month, Day, Year) Months Davs Hours Director 215-78-4355 1 € M 2 □ F 49 Yrs Maryland June 21,1963 Usual Residence of Decede filed within 72 hous are trailed Hygiene.

ed other than "natural", or items 23a or 28a-f show ed other than "natural" or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Baltimore Dundalk 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7904 North Boundary Road United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ş 1 ☐ Yes 2 🙀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Heritage Honda Elementary/Secondary (0-12) College (1-4 or 5+) 12 Years Estimator Body Shop Be permit. Page 1 and 2 should be file.
Department of Health and Mental Primportant: If item 27 is many injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James W. Brockwell, Sr. Peggy L. Knickman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Audrey S. Brockwell (Wife) 7904 North Boundary Road Dundalk, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location ~ City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Sacred Ht. of Jesus Cem12/14/2012 4 ☐ Donation 5 ☐ Other (Specify) Dundalk, Maryland 21. Signature of Suneral Service Licensee Michael Neiser 22. Name and Address of Facility Luda-Ruck Funeral Home of Dundalk, Inc. uh 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Myocardial disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner tuper tensive Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due o (or as a consequence of): Examir the attending physician and ched for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Day Year 9 Unknown 9 Unknown P.O. signed by d Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Dicherry wellton Records, 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perform eral Director: After this certificate I filled in by the funeral director, pag performed? 1 🗌 Yes 2 No Division of Vital ister's 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Residence Other: 4 Nursing Home 5 Residence 6X Other (Sp မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No death Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined after To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore. Durt Cuy 7566 31. Date filed (Month, Day, Year)
DEC 1 4 2012 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 1 Physician/ William Foley Beauchamp Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gilchrist Towson Baltimore . Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 7. Age (In vrs. last birthday) 8. Date of Birth Days Min. (Month, Day, Year) 220-54-9162 Director 1 🛛 M 2 🗆 F 57 5/27/1955 Maryland end Mentel Hygiene. Is marked other than "neture!", or Items 23e or 28a-f show reumatic event, the Medical Examirer must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours efter death with the Maryland Director 1 Ves 2 X No Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2121 Pot Spring Road 21093 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc þ 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Real Estate Appraiser Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be Edward L. Beauchamp Caroline Bradshaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pege 1 and 2 sh ment of Health er ant: If item 27 is Janice B. Beauchamp / wife 2121 Pot Spring Road Timonium, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Removal from State injury or Department important: it Hilltop Serv. Corp. 12/13/2012 | Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Fundal Samuello. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Death Immediate Cause (Final Pinysician/ disease or condition resulting in death) VOTEOPIC CATERAL SCHEROSIS MAR Medical Due to (as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the ettending physicien end completely filled in by the funeral director, page 2 should be detached for use as the burlal-transit ettending physicien end I for use as the burlai-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Pregnant at time of death JYes 2 ☐ No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of Jause of death?

1 Yes 2 No autopsy 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) +OSPICUE 1 ☐ Yes 2 ☐ No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier ddress of person who completed cause 32. Registrar's Sid State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 40550 State Registra Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ urnes 9, Zoiz VISTE Medical 4a. Facility Name (if not institution, give street and number) 4b City, Town, or Location of Death 4c. County of Death Examiner Hmore ohns TOOK INS If Under 1 Year Social Security Number If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Funeral Hours Days Min. (Month, Day, Year) Director 1 5 M 2 🗆 F 212-76-4109 65 Mar, 17, 1947 MD Usual Residence of Deceden 27 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b Counts 10d. Inside City Limits within 72 hours efter death with the Maryland Director MD Baltimore Yes 2 ☐ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 1404 E. Lanvale St. 21213 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced Completed Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiens Important: If item 27 is marked other than any Injury or other traumatin event. College (1-4 or 5+) Elementary/Secondary (0-12) Unemployed Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Emmitt Holt Clarice Burnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Holt (brother) 1404 E. Lanvale St. Balto,Md 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bayview Crematory Dec. 13, 2012 Balto, Md 21. Signature of Funeral Service Licensee Calvin B. Scruggs Funeral Home Preston St. Balto, Md Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to Examiner Section to by list and tions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar the attending physician end Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ρ in the past 12 months? Month Year 5 Other (specify) Day Pregnant at time of death signed by the af 1 Yes 2 9 Unknown 2 🗌 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 10 3 Probably 4 Unknown 1 🗌 Yes within 24 hours after death.

To the Funeral Director. After this certificate has been signorphetely filled in by the funeral director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ᅆ 1 Inpatient 2 FR/Outpatient 3 I DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d Describe how injury occurred iniury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 \square Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and the of certifier 29c. License numbe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Orleans St. Baltimore, MD. 21287 TORAC MID 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Reg. No 20 Certificate of Death Decedent's Name (First, Middle, Last) Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death "spering 23 merks U If Under 24 Hrs. 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) Aug 22, Days 66 Director Maryland 214-44-0550 1 M 2 XGE 1946 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at within 72 hours after death with the Maryland 10a. State 10h Counts 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1235 Whispering Woods Way 21014 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married ò 1 ☐ Yes 2 ☑ No If Yes, Give 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Hygiene, other than "natural", Specify: 3 Widowed 4 Divorced Completed White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1 and 2 should be filed within the Halth and Mental Hygiens item 27 is marked other the 12 C&P Telephone Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Quinter Warren Beatrice Baranyi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorie Christine Myers /Daughter 2507 Parliament Dr. Abingdon, MD 21009 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Page 1 Department of Important: If it 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dec 1 Beltsville, Maryland Chesapeake Crematory 2012 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Alternatives MO1585 Melocacc normor 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physic and oukemia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be execute page 2 should be detached for use as the burial-tran been signed by the attending physician and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Dav Year 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 autopsy performed 2 🗆 No 1 Tyes 2 2 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Tes 2 🗌 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

283 5 Smith

32. Registrar's Signature

NS Rajapaksem D

31. Date filed (Month, Day, Year,

D005 7-465

Battimore

21709

State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 8 aM ranco Decambar 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City_Town, or Location of Death 4c. County of Death Examiner Grove Adventist HOSPITA KOC MONTGOMER Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min (Month, Day, Year) 716-25-823 Director 1 M 2 F 76 -1935 20 Drea December 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director HOWOUR 10 1 Yes 2 No UMD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10 104 DIRO Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ğ Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates Specify: 3 ₩idowed 4 ☐ Divorced ASIAN Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) condary (0-12) College (1-4 or 5+) Domest Housewi Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ٥ an 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 043 Informant's Name/Relationship (Type, Pri aaughtee Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Davidsonville akemont MON 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 10220 Gwifford Delo MD20794 Koac 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final intracranial and sub arachnoid hemorrhage Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Éxaminer malianant pertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ą 1 ☐ Yes 2 🛱 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Alpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 07437 ecember 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville, Montad centeralist. 9901 Medical ijaya 20850 Kommi neni 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Chang nam

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ PM Medical 4a. Facility Name (if not institution, give street and number) Genesis **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Lanc Elder Care If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Social Security Number 7. Age (In yrs. last birthday) April 12 1924 Hours 1 M 2 X 88 **Director** 216-16-<u>0835</u> MD Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Maryland Anne Arundel Pasadena 1 ☐ Yes 2 🔀 No 0 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 1005 Duvall Highway 21122 USA items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. ò Completed by 1 Never Married 2 Married 1 Yes If Yes, Give be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify "natural", 3 Widowed 4 Divorced White Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 10 Homemaker Household Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Keilholtz ည James Ida Mae Parker t. Page 1 and 2 should by rtment of Health and Mer rtant: If item 27 is mark. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia German 1005 Duvall Hwy., Pasadena, MD 21122 20a. Method of Disposition Date 13 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot metro Crematory or other place) Dec 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service License 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1 Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line to not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Physician/ TULLIA disease or condition resulting in death) inknown Medical Due to (or as a consequence of) **Examiner** unknown Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events oronany certificate be executed Due to (or as a consequence of resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No Day Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. ģ signed to Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 No 1 Yes Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ည 4 Nursing Home 5 Residence 6 Other (Specify, Director: After this of in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred or Attending Natural 5 Pending iniury Accident after death. 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined within 24 hours a To the Funeral D Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature at 29c. License number

State Registrar ess of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 193 20年2 Cochran Howard 01:25 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Glen Burnie 400 Rose Avenue If Under 1 Year If Under 24 Hrs Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months Hours Director 216-62-4377 1 X M 2 - F MD 59 Yrs Sept. 10 1953 Usual Residence of Decedent 28a-f shov event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Glen Burnie Anne Arundel Maryland 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21061 USA 400 Rose Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force 0 Black, White, etc. δ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 72 hours after White 1 Yes 2 No Specify: "natural" Completed 3 Divorced Specify Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Fage 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If Item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Electrical 12 Electrician Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname)
 Myrtle C. Harthausen ဂ္ Cochran Myrtle Thomas E. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 400 Rose Avenue, Glen Burnie, MD 21061 Debra Cochran (spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 07 permit. Fage 1 a
Department of I
Important: If ite
any injury or ot 20c. Location - City or Town, State 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State Metro Crematory Trc. Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 21. Signature of Funeral Service Licens 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Par 1. Enter the disease, or complications that cause the shick, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest RIO Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir page 2 should be detached for use as the burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed to hours after death. Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68766 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown 24b Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform After this certificate Yes 2 N 1 ☐ Yes 2 ☐ No To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to predical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manne of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending ☐ Accident 1 Tes 2 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check ρ3 🔲 Certifying Nurse Reactitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only ope 29b. Signature 29d. Date signed (Month, Day, Year) 12/04/2012 ~() 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harjit Singh, M.D 5410-A Ritchie Highway, Brooklyn Park, MD 21225 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Annie Mae Davis 19:49 Medical 4c. County of Death Examiner Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Honrie **Funeral** In yrs. 91 last birthday 8. Date of Birth 9. Birthplace (State or Foreign 225-28-7829 Months 11/17/21 Director 1 □ M 2 🏝 F VΆ ms 23a or 28a-f show must be notified at 10b. County 10a. State **Funeral Director** 10c. City, Town or Location 10d. Inside City Limits N/A MD Baltimore X☐ Yes 2 ☐ No 10e. Street and Number 32 N. Wheeler Ave 10f. Zip Code 10g. Citizen of What Country? 21223 USA ו "natural", or item ledical Examiner ת 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ⚠ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. African þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 □ Divorced Completed Amer. Year or Dates Page 1 and 2 should be filed within 72 hour ment of Health and Mental Hygiene. ant. If Item 27 is marked other than "natulury or other traumatic event, the Medical ury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Owner Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 21244 7872 Cornerstone Way, Windsor Mills, MD Evelyn Harris/Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State permit. Page Department o Important: If any injury or once. 12/20/12 Balt., MD Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Syrvice Licensee 22. Name and Address of Facility Hari P. Close F.Svs, PA 5126 Belair Rd, Balt., MD 21206-5105 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Onset and Death molications disease or condition resulting in death) Medical r as a consequence of) **Examiner** Sequentially list conditions Examiner rany, leading to immediate cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year Yes 2 No 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe Director: After this certificate Yes 2 No 1 Yes 2 No filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: မ 1 🗌 Inpatient 2 🗶 ER/Outpatient 3 🗌 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 28b. Time of 28d. Describe how injury occurred 1X Natural injury 5 Pending Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a 29a. Certifier 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 06-2011

State Registrar (Item 23a) (Type, Print)

who completed cause of death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** E. Domino 2.00 AM 07 12 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** South River Nursing Home Edgewater MD Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Yes 5/16/19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 321-10-1333 1 M 2 K F 93 Director Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits MD Anne Arundell Edgewater 1 ☐ Yes 2 No Director 10e. Street and Number 144 Washington Road 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be in 21037 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. ☐ Yes 2☐ XX Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes XXNo Specify. Ş Q 3℃Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be william Honkanen Muikku Hanna ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Domino 3091 Scottsborough Way, Riva MD 21140 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Heights Crematory 12/15/12 Chicago Heights IL 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Firmeral Service Licensee Victor P. Doda 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501, E. Fort Avenue, BAltimore MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final andiac ary/hmcs **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as for use 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 5 ☐ Other (specify) P.0 ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, δ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? page 2 1∐ Yes 2/1/0 Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: e Hospital or Attending I 24 hours after death. 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours and warm.

To the Funeral Director: / investigation 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Dous 37 0 9

State Registrar 31. Date filed (Month, Day, DEC 1 4 201

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STE # 205 BONG

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HAWLA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40557 Certificate of Death 2. Date of Death 3. Time of Death Physician/ Medical 9:38 AM December 4a. Facility Name (if not institution, give street and number Examiner 4c. County of Death th etmore bosp 17a None If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) B. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Director Hours 1 M 2 🗆 F 56 1956 MD permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examilian must be notified at once. 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Baltimore MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubart, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industri (Specify only highest grade completed) College (1-4 or 5+) bover Be buen port 3505 Hymore MO Baltimore, lethoer of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) umberland 21. Signature of Funeral Service Uicenner Approximate Interval Between Caset and Death Approvious Approvious Republicat Examines Constitution of the 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated as part of the cause) Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician end should be detached for use es the burlal-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Certificate: To npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Mosth, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Natural
Accident
Suicide ה אמפא ה 24 hours after death. he Funeral Director: After a in by the fu 5 Pending pel 1 Yes 2 No 30A M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hours to the Fune completely fi 29a. Certifie (Check 29c. License number D0066614 11,2012 December 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jenniter, b. Berkeley, MD Sinai Hospital of Baltimore 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of M	aryland /		rtment of I tificate of L		nd M	ental Hyg	giene Reg. No. 2 (112	40558
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	Funeral Director			□ M 2 🖾 F	91	Yrs.	Months Days		Min.	(Month, Day	Year)	Coun	
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	the M	٩	10e. Street and Number				10f. Zip Code				10g. Citizen of	What Cour	
	n with	Funeral Director	301 German Hill	Road				21222			United	Stat	es
	r item iner n		11. Marital Status	12. Was Decedent E Armed Forces?		13. W	as Decedent of H Yes, specify Cuba	ispanic Origin ın, Mexican, F	n? (Spec Puerto P	cify Yes or No- lican, etc.)		ce - Americ	
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Baltimore, Maryland 21215-0036	permit. Page 1 of Pepartment of I Importent: If Ite eny Injury or of once.		1 Burial 2 Cremation 3 Donation 5 Other (Special	fy)	Holly	Hil	atory or other place I Mem. G	dns. 1		ate +/2012	20c. Location Midd1	-	er, MD
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		by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant at 9 Unknown	2 Fetal deat		Ectopic pregnanc Other (specify)	ey .				ate of delive	ery Day Year
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ξ	hysici nis cer il direc	<u></u>	examiner? 1 Yes 2 No	Hospital: 1	ent 2 ER/O	utpatient	Oth	er:		ne 5 🗆 Reside	ence 6 🖸 Oth	er (Specify	HOSPICE
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Ξ	tal or rs afte el Dire		4 - Hornicide determined	building, etc						City or Town		or or ridia.	Troute Harrison,
	To the Hospital or Attent within 24 hours after deat To the Funeral Director: completely filled in by the	Medical	(Check 2 ☐ Medical Exam	sician: To the best of iner: On the basis of ex	amination and/o	or investi	gation, in my opinic	on, death occu	irred at t	he time, date an	d place, and du	e to the cau	use(s) and manner stated.
	To the within 2 To the comple	Σ	only one) 3	se Practitioner. To the	best of my kno	wledge,	death occurred at t 29c. License		and plac		e cause(s) and i 9d. Date signe		
	/		-mpm	1-4	1	7	09	1636	0		^		
	5m		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type, Pr	int) 2/11/		7		0		R 10,2012 wMP ZIZCY
	Stat	Α	31. Date filed (Month, Day, Year)	32 Tomatra	Power M	16	14 1Vd	etil 1	11/20	15 STOK	PETBAL	Twit	OMPGIZCY
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 081 DASHEFF DEZEM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SINAL BALTIMORE N/A HOSPITAL BALTINO If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) Funeral Months Hours 218-05-6712 Director 1 X M 2 □ F 04/08/1922 MD 90 Usual Residence of Decedent r then "netural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Ves 2X No BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 6 POMONA WEST, 21208 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married ξ filed within 72 hours after 1 Yes 2 No Specify. Specify: WHITE If Yes Give 3 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 2121 Elementary/Secondary (0-12) College (1-4 or 5+) CONSTRUCTION CONTRACTOR Be Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental should be SCHWARTZ ROSE DASHEFF NATHAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health and Important: If item 27 is meny Injury or other traum once. Page 1 and 2 sh ment of Health a 6 POMONA WEST, #1, PIKESVILLE, MD 21208 HILDA DASHEFF/WIFE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
BETH JACOB
ANSHE VESHEAR 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 12/13/2012 ROSEDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or concications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Kespina disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of). attending physician and for use as the burial-tral sit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death ate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performe 1 ☐ Yes 2 ☐ No this certificate director, 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Tyes 1 Npatient 2 ER/Outpatient 3 DOA hin 24 hours after death.

the Funeral Director: After this

mpletely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of

Registrar

State

Cithretinson

31. Date filed (Month, Day, Year)

Patermont

MD 2121

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SINA HOSPITAL

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40560 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ :64 monds Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kockwai tounta If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 215-30-855 7. Age (in yrs. last birthday) **Funeral** Months Days Hours 1 M 2 🗆 F Director 8 permit. Page 1 and 2 should be filed within 72 hours efter death with the Maryland Depertment of Health and Mental Hygiene. importent: if item 27 is marked other than "netural", or items 23e or 28a-f show eny injury or other treumatic event, the Medical Evaniner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director 1 Yes 2 No ewood toro 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21040 ROCKWai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates. 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married <u>چ</u> 1 Yes 2 No Specify: Specify: Black Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Be 18. Mother's Name (First, Middle, Maiden Surname) 17_Father's Name (First, Middle, Last) ည Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type, Print) Edmond - Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other, Date Burial 2 Cremation 3 Removal from State Crownsville 12/14/2012 rownsville Vet Donation 5 Other (Specify) March F/H-East 22. Name and Address of Facility of Funeral Service Li 1. Enter the disease, or complications that caured the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ate Cause (Final Pnysician/ distrife or conunc returning in death) e or condition Medical consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury To the Hospitei or Attending Physician: The lew requires that the death certificate be executed within 24 hours after death.

To the Funerai Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit sate has been signed by the attending physiclan end page 2 should be detached for use es the buriel-transit Exami that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day 4 Pregnant at time of death 9 Unknown 5 Other (specify) 2 No 1 ☐ Yes 2 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Dunknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗌 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ 1 🗌 Yes 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Medical Certificate: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29d. Date signed (Month, Day, Year) 29b. Signature and july

*5*¹ √ State

31. Date filed (Mo

erson who completed cause of death (Item 23a) (Type, Print)

egistrar's Signatu

022

2012

12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Dep	artment of Health and I <i>rtificate of Death</i>	Mental Hygier Reg.	
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physicia Medic		Brenda M. Elliott		December	10, 2012 2:00 P M
1	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Death
wet.			9335 Maxwell Court	Laurel		Howard
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 XF	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)
			Usual Residence of Decedent 44		Sept 10,	1968 Wisconsin
	land shov	호	10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits
	Mary 28a-1 otifie	Director	MD Howard	Laurel		1 ☐ Yes 2 🛣 No
	th the		10e. Street and Number	10f. Zip Code	_	Citizen of What Country?
	th wif	Funeral	9335 Maxwell Court	20723		Jnited States
10	r dea or itel	by Fu	11. Marital Status 1 □ Never Married 2 ☒ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	oecity Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.
93	is filed within 72 hours after death with the Maryland they giene. A to Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	q pe		1 ☐ Yes 2 🗷 No Specify:		Specify: White
2-0	hour fnatu dical	Completed		dent's Usual Occupation kind of work done during most of work	king 16b	o. Kind of Business/Industry
21	l within 72 /giene. ner than '	mo	Elementary/Secondary (0-12) College (1-4 or 5+)	OO NOT use retired)		7' - b
2	d with the rut, the rut, the	Be C	17. Father's Name (First, Middle, Last)	ppsychologist		ediatric Healthcare
Maryland 21215-0036	be filed ental Hy ked oth ic event	To E		Christi	ne (First, Middle, Maid ne Mager	en Surname)
37	should be fill and Mental 7 is marked of raumatic eve		Kenneth Fiechter 19a. Informant's Name/Relationship (Type, Print) 19h. Mail	ng Address (Street and Number or Rui		vor Town State Zin Code)
Ĕ	12 sh alth al 27 is rrtrau			=	rel, MD 20	
J.e.	1 and of Hea fitem		20a. Method of Disposition 20b. Place of Disp			: Location - City or Town, State
<u>m</u>	Page nent ant: It		I Dullar 2 24 Oremation o D Nemova nom otate	ney Crematory 12/	15/2012	Woodbine, Maryland
Baltimore,	permit. Page 1 and 2 should be fo Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e once.					P.O. Box 784 larksville, MD 21029
			231. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	nysician/		Immediate Cause (Final	ltiforme		Onset and Death 7 years
	Medical Examiner		resulting in death) Due to (or as a consequence of):	02_01		
	LAUIIIIICI	Je.	Sequentially list conditions, b.			
	ed nsit	Examiner	If any, leading to immediate Due to (or as a consequence oi), cause. Enter Underlying Cause (Disease or injury			
	xecuto n and al-trar	Еха	that initiated events resulting in death) Last C. Due to (or as a consequence of):			
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376	ificate g phy as the	Med	TE SERVICE			I STATE OF THE STA
39 ×	eath certificat attending ph I for use as th	an/l	F FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1	☐ Ectopic pregnancy		23d. Date of delivery
Box 687	death	Physician/Me		Other (specify)		Month Day Year
P.O.	es that the dea signed by the a I be detached f		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e Did tobacc	to use contribute to the cause of death?
ر. ت	res th signe	d by				2 X No 3 ☐ Probably 4 ☐ Unknown
ğ	/ requires been sig should t	Completed			24a. Was an	24b. Were autopsy findings available
ecc	The law ate has page 2	Jub			autopsy performed	prior to completion of cause of death?
<u>~</u>	in: Th ifficate for, pa	Be Co	25. Was case referred to medical	26. Place of Death (Chec	1 Yes 2	No 1 Yes 2 No
Vita	ysicie is ceri direct	To B	examiner? 1 Yes 2 XNo Hospital: 1 Inpatient 2 ER/Outpatie	Other:	lome 5 X Residence	e 6 Other (Specify)
of	ng Ph ter thi ineral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of injury (Month, Day, Year) injury		28d. Describe how in	
lon	eath. or: Af the fu	ifica	2 Accident Investigation 3 Suicide 6 Could not be	M 1 Yes 2 No		
Division of Vital Records,	or Att	Certificate:	4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	spital ours a eral [29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place a	and due to the cause(s	s) and manner as stated
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only one) Certifying Nurse Practitioner: To the best of my knowledge, deam only one) Certifying Nurse Practitioner: To the best of my knowledge	tigation, in my opinion, death occurred a	at the time, date and pla	ace, and due to the cause(s) and manner stated.
	To th Within To th comp	-	29b. Signature and the of certifier	29c. License number		Date signed (Month, Day, Year)
			> Edward Theeds	D0023601	i	12/12/12
, i	5 v		30. Name and address of person who completed cause of death (Item 23a) (Type,			
1				G020 Columbia,	MD 21044	
	Stat Registra		31. Date filed (Month, Day, Year) DEC 1 4 2012 Series 32. Registry's Signature DEC 1 4 2012			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		, roi	artment of Health and Mental tificate of Death	Hygiene Reg. No. 20	2 40562
		Decedent's Name (First, Middle, Last)	2 Date of	of Death	3. Time of Death
Physic Medi/		MINNIE EVANS 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Day Year 10 20/2 4c. County of Dea	
Exami	ner	Johns Hopkins Bayview Medical Center	Baltimore	N/	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8, Date of		rthplace (State or Foreign buntry)
Director		220-24-0449 93 Yrs. Usual Residence of Decedent			rginia
ryland show at	_	10a. State 10b. County 10c. City, Town or Lo	cation		10d. Inside City Limits
he Ma 28a-f s	Director	MD Baltimore		lalk	1 ☐ Yes 2X No
3a or		10e. Street and Number 3940 North Point Road	10f. Zip-Code 21222	10g. Citizen of What Co	,
death	Funeral		Was Decedent of Hispanic Origin? (Specify Yes o If Yes, specify Cuban, Mexican, Puerto Rican, etc.		erican Indian,
s after ", or it amine	by Fu	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 XNo Specify:	Specify:	
15-0036 72 hours aft 'natural", or dical Examir	ted	15. Decedent's Education 16a. Dece	dent's Usual Occupation	16b. Kind of Business	hite s/Industry
rithin 7 ne. Medi	Completed		kind of work done during most of working DO NOT use retired)		
filed w Hygier Ither th		12 Years Home	18. Mother's Name (First, Mi	Own Home of the last of the la	2
lan lid be fental rked o	To Be	Lloyd J. Thomas	Nelli	e Fitzgerald	
i, Maryland Z IZ I D-UU3D and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene. n 27 is marked other than "hatural", or items 23a or 28a-f show her traumatic event, the Medical Examiner must be notified at			ng Address (Street and Number or Rural Route N		
e, Mi 1 and 2 Health a em 27 ls ther tra		Mr. James R. Evans (Son) 112 20a. Method of Disposition 20b. Place of Dispo	28 Park Break Drive Fr	20c. Location - City o	
Dalkimore, Marylia permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 Is marke any injury or other traumatic.		XXBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, cres	matory or other place) Iem. Gdns. 12/13/2012		
Dalti			2 Name and Address of Facility Duda-Ruck Funeral Home		•
o #9 E #9		23a. Fant 1. Enter the disease, or complications that caused the death. Do not ent	7922 Wise Ave. Dundalk	• Maryland	21222
District Control		shock, or heat alluse. List only one cause on each line. Immediate Cause That discount on the cause on each line. A 5 C V D	er the mode of dyling, such as cardiac or respirati	ory arrest,	Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death) a. Due to (or as a consequence of):			Long standing
Examiner	<u>_</u>		FAILVE		2 days
ed	Examiner	Sequentially list conditions, if any, leading to immediate cause End Underlying Cause (Disease or injury			
execut n and ial-trar		that initiated events resulting in death) Last . C. Due to (or as a consequence of):			_
Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and arial director, page 2 should be detached for use as the bunal-transitions.	dical	d			
ertificat ling phy se as th	a a	IF FEMALE: 23b Was decedent program: 23c. If yes, outcome of pregnancy			
us, r.O. box of uires that the death certification is signed by the attending lid be detached for use a	Physician/M	in the past 12 months? 1 Live birth 2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)	23d. Date of de Month	Day Year
t the d	Phys	9 Unknown 9 Unknown			
es tha	þ	Part II. Other significant conditions contributing to death but not resulting in the		Did tobacco use contribute 1 □ Yes 2 □ No 3 □ F	to the cause of death?
w requires to been signed is should be	Completed				autopsy findings available
he law e has t	ошо		6	autopsy prior to performed death?	o completion of cause of s 2 □ No
VICAL Cian: T ertificate ector, p	Be C	25. Was case referred to medical examiner?	26. Place of Death (Check of		
Physic Physic this ce	ည	1		Residence 6 Other (Speribe how injury occurred	ecify)
eath. or: After the funer	ation	1 (☑ Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No	noo non mary occurred	
r Atter er dea rector	ertification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, str building, etc. (Specify)		on (Street and Number or F r Town, State)	Rural Route Number,
oital or oral or oral Dir	0	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	Occurred at the time, date and place, and due to	the cause(s) and manner	as stated
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has to completely filled in by the funeral director, page 2	edical	(check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.			
To the To the Comp	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mon	
1/ 4.4		1 Thin	D-0061115	December	10, 2012
4 M		30. Name and address of person who completed cause of death (Item 23a) (Type,	4940 Eastern	Avenue, Baltim	ore, MD, 21224
	ate	31. Date filed (Month, Day, Year) DEC 1 4 2012 Registrar's Signature	Mal	,	
Regist	rar	DECT TOTAL			

DHMH 17 Rev 1/2001 11595

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40563 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ^{Day}2012^{Year} Fluri Gene 9:30A J. 13 Dec Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Westminster Carroll Westminster Ridge If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 205-26-1428 Director 85 1 XM 2 □ F Yrs 3-12-1927 PA item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits MD Carroll Westminster 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 718 Fairfield Ave. 21157 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 A No Specify. If Yes, Give Specify: white 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Accounting 12 Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph D. Fluri Jennie Delasanti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gene P. Fluri-son 718 Fairfield Ave., Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Marriottsville, MD 12/18/12 4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn Mem 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fletcher Funeral & Cremation 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a cons To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the Inneral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 🗆 No I ☐ Yes 2 ☐ № 25. Was case referred to me a Certificate: To Be 26. Place of Death (Check only one) 1 🗌 Yes 2 🗌 Ne Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 Ø Other (Specify) 27. Mann f Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 20050763 30. Name and address of person who ompleted cause of death (Item 23a) (Type, Print) 21157, Epresto Menduza ANC, Westminster, MD 1AShins ton

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

UEU 1 = 2012

32. Registrar's Signature

OCME 2006

Registra DHMH 17 Rev 1/2001

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

29c. License number

O.C.M.E.

Ling Li, MD 31. Date filed (Month,

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a)

29d. Date signed (Month, Day, Year)

December 8, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40565 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 12 WILLIAM, HENRY, PORD 1:30 PM Medical 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NIA BALTIMORE BALTIMORE VA MEDICAL CENTER Social Security Number 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours Director 1 M 2 F 66 Yrs. Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified at</u> 10a. State within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Hmore 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. Man nes i and 2 should be filed within 72 hours aft f Health and Mental Hyglene, item 27 is marked other than "natural", 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Specify: 131ack 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 cme Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) injury or other 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Surial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatury of Funeral Service Licens Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ACUTE KIDNEY disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner PERITONITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events WEEKS Due to (or as a consequence of). METASTATIC COLON YEARS ig physician and as the burial-trar resulting in death) Last Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 🔲 Ectopic pregnancy ğ 4 ☐ Pregnant 9 ☐ Unknown 5 Other (specify) Pregnant at time of death Day ed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, TYPE II DIABETES 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown PNEUMONIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Director: After this certificate has autopsy 1 ☐ Yes 2 🛣 No X Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🕅 No Other: 4 Nursing Home 5 Residence 6 Other (Specify, ဂ္ 1 XInpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a

To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the courses) and memory as state only one) 29b. Signature and title of certifier NPI: 1184883217 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHAHAL 5. JON MD S. GREENE ST, BALTIMORE, MD 2120 State 32. Registrar's Signatur Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 40566 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ James Melvin Fenhagen 2012 00:35 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Upper Chesapeake Medical Center Harford Bel Air If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Dav. Year) **Director** 216-05-6544 1 XM 2 D F 1919 93 Jan. 16, Maryland Usual Residence of Decedent artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Harford Fallston 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 2714 Beechwood Lane 21047 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14 Bace - American Indian Armed Forces by Black White etc. 1 Never Married 2 Married XYes 2 No 3altimore, Maryland 21215-0036 White 1 Yes 2 No Specify: If Yes Give 3 ₩ Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 8 Fire Fighter City of Baltimore Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George Howard Fenhagen Lillie Belle Follin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is nany injury or at Mary D. Kanely / Daughter 1603 Emmorton Road, Bel Air, Maryland 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Highview Memorial Gdn 12-14-2012 | Fallston, Maryland Donation 5 Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ freumoma disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner (Mysohwa Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death 1 Yes 2 No 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed? Yes 24 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital No. 1 Tes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)

Division of Vital Records, P.O. Box 68760

Hospital or Attending 24 hours after death.

27. Manner of Death

1 Natural

Accident

29b. Signature and title of certifier

31. Date filed (Month, Day,

Suicide

4 Homicide

5 Pending

Investigation

determined

6 Could not be

2012

Certificate:

Medical

Registrar DHMH 17 Rev 06-2011 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

injury

28c. Injury at

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Upper Chesopeale Drive

1 Yes 2 No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

00004015

29c. License number

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,

12/10

29d. Date signed (Month, Day, Year)

21014

28a. Date of injury (Month, Day, Year)

MO

500

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 40567 Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Day Fletcher Elsie Ann 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Rosedale ranklin Square If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Security Number 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) Hours Days Min (Month, Day, Year) 216-44-5596 **Director** 65 1 🗆 M 2 🛛 F June 7,1947 Maryland ms 23a or 28a-f show must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Dunda1k 1 Yes 2 X No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1927 Robinwood Road 21222 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc þ 1 Never Married 2 Married ☐ Yes 2 X No Yes, Give 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Specify Completed White Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation
(Give kind of work dane during most of working
life. DO NOT use retired)
Director of Corp Information
Technology 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Years Years R.G. Stee1 Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျပ Annie Leebrick Leslie Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1927 Robinwood Road Dundalk, Maryland 21222 Jean H. Fraser (Friend) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1.
Department of I
Important: If it
any injury or of 1 Burial 2 Cremation 3 Removal from State Donation 5 St Other (Specify) Entombment Gardens of Faith Cem. 12/15/2012 Baltimore, Maryland 21. Signatur of Funeral Service Licensee Dennis Carvoli Bullan Ruck Fundival Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition Jevere Pulmenary Ventricular 51000 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ Live Birth 2 Live as Live Pregnant at time of death Unknown in the past 12 months? Month Day Year g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy perform death? 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 ☑ No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 24 hours after death Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) DOOU+697

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Registrar DHMH 17 Rev 06-2011 9000 Franklin Square Drive

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sanc

Nelia 31. Date filed (Month, Day, Year) Crespo

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For State Registrar		State of	Marylan	d / Depa	artment of latificate of L	k. Ensure A Health and M Death	lental Hygio	ene Leg	12	40568
Physicia Medic			ther	ine F	1422				2. Date of Death	8 Day 2	Year	Time of Death
Examin	er	4a. Facility Name (if not instit 1209 Hills 5. Social Security Number		le Rd			4b. City, Town, or Location of Death Pasadena If Under 1 Year If Under 24 Hrs. 8. Date of			4c. County of Death Anne Arundel		
Funeral Director		214 14 721 Usual Residence of Deceden	8 1	M 2 ≱ F	91	Yrs.	Months Days	Hours Min.	8. Date of Birth	Î921	Country)	e (State or Foreign MD
Maryland :8a-f show tified at	Director	10a. State 10b. Co		undel		, Town or Lo asade:						Inside City Limits 1 Yes 2 No
n with the is 23a or and the in	Funeral D	10e. Street and Number 1209 Hills	ide F	≀d			10f. Zip Code	21122	10	-	What Country?	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	by	11. Marital Status 1 □ Never Married 2 □ 3 🗷 Widowed 4 □ Divo	Married	12. Was Decede Armed Force 1 ☐ Yes 2 If Yes, Give Year or Date	s? 🗶 No		Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 🛣 No	ispanic Origin? (Spe an, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)		e - American lick, White, etc.	
hin 72 hou ne. than "nat u ne Medical	Completed	(Specify only Elementary/Seconday (0-			or 5+)	(Give life. D	O NOT use retired)	during most of workii	ng 1		usiness Indust	ry
oe filed wit intal Hygie ced other c event, th	To Be C	1 2 17. Father's Name (First, Mid	. ,	 Villian	, mhoa		omemake:	18. Mother's Name	(First, Middle, Ma ates Va		e)	
2 should the and Me 27 is mark		19a. Informant's Name/Rela	tionship (Typ	e, Print)		19b. Maili		and Number or Rura		City or Town, S	State, Zip Code	
⁵ age 1 and ient of Hea int: If item ry or othe		20a. Method of Disposition 1 Burial 2 Crema 4 Donation 5 Ott	ation 3 🗆 F	Removal from St	20b. P	lace of Dispo emetery, crei	osition (Name of matory or other plac		Date 2	0c. Location -	- City or Town,	State
permit. Popartm Importa any inju		21. Signature of Emperal Services	vice License	е		22	2. Name and Addre		Gonce	Funer	al Ho	
Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):										
cate be executed physician and the burial-transit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	3	o	as a consequ							:
ficate be e g physicia as the buri	Medical			d						1		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affer death. To the Funeral Director, Affer this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	2		th 2 🗌 Feta nt at time of c	Ideath 3	Cotopic pregnant Cother (specify)	ру			ate of delivery onth Day	/ Year
uires that t in signed b uld be deta		Part II. Other significant con	NSI	30		ulting in the t	underlying cause gi	ven in Part I.			ribute to the ca	ause of death? y 4 🗆 Unknown
sician: The law req certificate has bee irector, page 2 sho	Completed by	Diabeta	2 W	ell, tus	II				24a. Was an autopsy perform	ed?		findings available etion of cause of
hysician: nis certifica director, p	To Be (25. Was case referred to medexaminer? 1 Yes 2 No		ospital: 1 🔲 Inp	patient 2 🗆	ER/Outpatie	26. P	ace of Death (Check er: 4 Nursing Ho			er (Specify)	
tending Patenther, After the funera	Certificate:	2 Accident In	ending vestigation could not be		Day, Year)	28b. Time o injury	M 1 □	⟨? Yes 2 □ No	28d. Describe how			
pital or At burs after of eral Directilled in by		4 Homicide de	etermined	building	etc. (Specify)	reet, factory, office	a, date and place, and	28f. Location (Stre City or Town,	State)		ite Number,
o the Hos vithin 24 ho o the Fun-	Medical	(Check 2 Medi	ical Examin ifying Nurse	er: On the basis	of examination	and/or inves	tigation, in my opini	on, death occurred at le time, date and place	the time, date and e, and due to the ca	place, and du ause(s) and ma	e to the cause(s	
\		30. Name and address of pe	2 ly	mpleted cause	V death (Item	23a) (Tyne	Doo Print)	21703		12 11	-12	
}-\V Sta	te	31. Date filed (Month, Day, Ye	F 6	achy	strar's Signat	8651		en (1 2000	IRASK	1 Pas	uden	21,22

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 2648 P -DOLPH SLLER Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 265-42-2944 1**XX**M 2 □ F 97 Nov 11,1915 Poland Poland Usual Residence of Dec 28a-f show 10a. State iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Annapolis 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 111 Sunset Drive 21403 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Force Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2X No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 ☐ No Specify. "natural", 3 X Widowed 4 □ Divorced White Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4 or 5+) Cabinet Maker 4 Carpentry other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental မ Nathan Schaber (Unk) Esther 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Annapolis, Maryland 21403 Jane Lawton (Daughter) 111 Sunset Drive 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Sinai Mem Parks Donation 5 Other (Specify) 12/21/12 Los Angeles, CA ure of Funeral Service Licensee 21. Sign 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, Inc. 7250 Washington Blvd., Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, s shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between THILUNE ESPIRA Physician TBR disease or condition resulting in death) Medical Examiner NEOPLASA Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Pregnant at time of death Day Year 2 No detached 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by EMEMA 1 Yes 2 No 3 Probably 4 Unknown Completed HROML 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospita 2X No Other: မှ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manper of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 🗌 Yes 2 🗌 No 1 Natural 5 Pending after death. Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined Medical within 24 hou

To the Funer

completely file 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b, Signature and title of certifie 29d. Date signed (Month, Day, Year) 12 2 12 ANNE 21401 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day,

Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day М December 5 Medical Michael James Gilbert 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hebrew Home of Greater Washington Rockville Montaomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Director 1 2 M 2 D F 285-36-2950 70 December 25, 1941 Ohio i Hygiena. other than "naturel", or itsma 23a or 28e-f show vent, the Medical Examiner must be notified at 10a State 10b County Pega 1 and 2 should be filed within 72 hours after deeth with the Merylend 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20852 United States 6121 Montrose Road 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Yes 2 No
If Yes, Give Black White etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☒ No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Office Staff Federal Government ith and Mentai Hygler 27 is merked other raumetic event, å 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sally Bloch Edward Gilbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Haeith Jonathan Lebby / Nephew 619 Warfield Drive, Rockville, MD 20850 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State cemetery, crematory or other place) parmit. Pega Department of Important: M any injury or once. apitol Heights, MD 4 Donation 5 Other (Specify) Chesed Shel Emes 12/7/2012 21. Signature of Funeral Service Licensed 22. Name and Address of Facility Danzansky Goldberg Memorial Chapels Inc. 1170 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter the disease, or complishock, or heart failure. List only one mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ erebral Vascular Medical resulting in death) Examiner obstructive hydrocephalus 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). b Hospital or Attending Physician: The lew requires that the death certificate be executed 24 hours after deeth.
Pruneral Director: After this certificate has been signed by the attending physician end istely filled in by the funerel director, page 2 should be dateched for use es the buriel-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Dav 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ś Completed 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an perform 2 X N Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 ☑ No Other: 4 🗖 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1 Natural work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical To the Hoep within 24 hou To the Funer compiately fil 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Farli mina D0064871 12-5-2012

DHMH 17 Rev 06-2011

State Registrar Montrose

MD

20852

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

6121

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 40571 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 1 2012 5:34 A M Beverly Janet Gaynor Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Funeral 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign Days Hours Director 071-22-9112 1 M 2 X F Usual Residence of Decedent 1928 Dec 11. New York 83 show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f shown any Injury or other treumatic event, the Medical Examiner must be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? Funeral 14500 Kelmscot Drive 20906 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black. White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Early Childhood Teacher Educátion Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Celia Allison Abraham Fox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14500 Kelmscot Dr. Silver Spring, MD 20906 Nathan Gaynor / Husband Baltimorle, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🗶 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Journey Crematory 12/13/2012 Woodbine, Maryland Signature of Funeral Service Linea Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Tu MO1251 26a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician Due to (or as a consequence of): disease or condition resulting in death) hours Medical Examiner hours poyen Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Bilatera months is certificate has been signed by the ettending physician and director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 7 No
9 Unknown 4 Pregnant 9 Unknown Pregnant at time of death Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 1 Phopatient 2 ER/Outpatient 3 DOA this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident ☐ Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) e Funeral Di Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and tine of certifier 29d. Date signed (Month. Day, Year) 45 391 December 10,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chukwaenek Rocky le MD 20850 NWOSK 9901 medical Ctr Dr MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2012 Registrar

DHMH 17 Rev 06-2011

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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of N	Maryland / Dep Ce	artment of He		, ,	jiene leg. No.2012	1.0573
	Physicia	an/	Decedent's Name (First, Middle, Last)			2	2. Date of Deat	th	3. Time of Death
C.,	Medic Examir	cal	Victor Allen Hill 4a. Facility Name (if not institution, give street and number)		4b. City, Town, or L		ecember	7, 2012	6:05 a. ^M
ز	LAdillii	ICI	Fox Chase Rehabilitation and N		Silver S			4c. County of Dea	
	Funeral	Г		age (In yrs. last birthday)			B. Date of Birth	9. Bi	rthplace (State or Foreign ountry)
	Director		577-90-4544 1 M 2 □ F Usual Residence of Decedent	51 Yrs.			May 28,	· .	ewaii
	yland f shov	향	10a. State 10b. County Maryland Montgomery	10c. City, Town or Lo					10d. Inside City Limits
	r 28a- notifii	Director	Maryland Montgomery 10e. Street and Number	Silver Spr					1 X Yes 2 ☐ No
	with the	Funeral	1131 University Boulevard West,	Suite 1001	10f. Zip Code 20902			10g. Citizen of What C	ountry?
	items items		11. Marital Status 12. Was Decedent	Ever in U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Specif	y Yes or No-	14. Race - Am	
36	after al", or xamir	d by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give 3 ☐ Widowed 4 ☐ Divorced	No	1 ☐ Yes 2 🏌 No		san, etc.,	Black, Whi	te, etc. Black
2-00	hours natur	lete	15. Decedent's Education	16a. Dece	dent's Usual Occupati	ion		16b. Kind of Business	
121	within 72 hours after death with the Maryland glehe. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed by	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or	life, D	kind of work done dui O NOT use retired) Clerk	ring most of working		Federal Gov	
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ylan	should be file and Mental 7 is marked or raumatic eve	ဥ	Ernest Hill			Rosetta Pag	ge		
Mar	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print) Ernest Hill/Father		ng Address (S <i>tr</i> eet an xon Hill Roa			City or Town, State, Z. MD 20744	ip Code)
Baltimore, Maryland 21215-0036	Page 1 and ment of Hea ant: If item ury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stat	20b. Place of Dispo	osition (Name of matory or other place)	Dat	-	20c. Location - City o	r Town, State
ıltim	교원보충 .		4 Donation 5 Oner (Specify) 21. Signature F Service Licens	Cremation Co		December	14,2012	Hanover, meral Home,	MD
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	Examiner	,		a consequence of):					
24	ed sit	Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequence of):					
	hat the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Exa	that initiated events c.	a consequence of):					
9	te be e hysicia he bur	dical	d						
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Division of Vital Records,	al or At s after o I Direct ed in by		4 Homicide determined 28e. Place of In	jury - At home, farm, stre tc. <i>(Specify)</i>	eet, factory, office	28f	Location (Str. City or Town,	eet and Number or Ru State)	ral Route Number,
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of only one) 3 Certifying Nurse Practitioner; To the	examination and/or invest	igation, in my opinion,	death occurred at the	time, date and	place, and due to the	cause(s) and manner stated.
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			I Cilan Kake	galin	J D522	261		12/14/2012	
393			30. Name and address of person who completed cause of a 1517 Hugo Circle, Silver Spring	death (Item 23a) (Type, B ND 20906	Fint)				
177. 1	Stat Registra	٠	31. Date filed (Month, Day, Year) DEC 1 4 2012 June 1	ar's Signature	,				

DHMH 17 Rev 06-2011

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examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other, 4 Nursing Home 5 Residence 6 Other: Scene 27. Manner of Death 1 Natural 5 Pending Nov 25, 2012 Nov 25, 2012 Positive in the property of the prop	Re I: The tificate		25. Was n	ase referred	to medica							26.Place	of Death	(Check o		es Z	INO	1 💇 10	o 2	
28a. Date of Injury 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 4	/ital		examir	ner?	_	_	pital: 1	Inpatient 2	ER/O	utpatien		1.7	_			Res	idence 6	✓ Other	: Scene	
Light Value of the state of th	of \ g Phy fter th	\vdash			INO		28a. Date	e of Injury						(?	28d. Descr	ibe how	injury occi			
	tendin death.	ation		9								1 Y	es 2 🗸	No	oubject (SHUL SE				

Division
To the Huspital or Attention 24 hours after death
To the Funeral Director:
completely filled in by the

Medical Certifica State

Assistant Medical Examiner 32. Registrar's Signature

(Specify) Townhouse / Rowhouse

6 Could not be determined

30. Name and address of person who completed cause of death (Item 23a)

3 🗸 Suicide

4 Homicide

29b. Signature and title of certifier

Russell Alexander MD. 31. Date filed (Month, Day, Year)

900 W. Baltimore Street, Baltimore, MD 21223

29c. License number

O.C.M.E.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1801 South Hanover Street, Baltimore, MD

November 26, 2012

29d. Date signed (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc.

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s).

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

offit David High		State of Maryland / Department of Health and Ment 1- For State Certificate of Death Registrar	ai Hygiene	Reg. No.	2012	40575
Physici Medical Exami	an/	1. Decedent's Name (First, Middle, Last) John D. High Jr.	2. Date of I		Year	3. Time of Death 1425 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of			ounty of Death	
		Baltimore County Detention Center Towson	out lo o		Itimore Cou	
Funeral Director		5. Social Security Number 6. Sex 17. Age (In yrs. last birthday) If Under 1 Year If Under 2 Yrs. Usual Residence of Decedent		. 11, 19	Foreig	hplace (State or n untry)
, any		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
Maryland 28a-f show d at once.	ģ	MD Baltimore Baltimore		Tan ou		1 Yes 2 No
5-0036 led within 72 hours after death with the Maryland tygiene. other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once.	Il Director	3801 Patterson Ave 2120	7		n of What Cour USA	
r death wi or items	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Original In Yes, specify Cuban, Mexican,			White, etc.	can Indian, Black,
urs afte tural", aminer	ক্র	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give k			d of Business/li	ndustry
D36 thin 72 ho ne. than "na ledical Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+)	use retired)		rans	motation
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica		17. Father's Name (First, Middle, Last) 18.Mother's	s Name (First, Midd	le, Maiden Su	ırname)	001,100
b, MD 2121: and 2 should be fil lealth and Mental I tem 27 is marked traumatic event,	To Be	19a. Informant's Name/Relationship (Type, Prin) 19b. Mailing Address (Street and Numl	ber or Rural Route	VI Number, City	or Town, State.	Zip Code)
O short		Sherry D. High 13801 Patters	on Aue	-	Hima	11 /
F F F		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date		cation - City or	4.1
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		4 Donation 5 Other Specify: 21. Signature of Funeral Servic Licenses 22. Name and Address of Facility	12/12/20 Howel	14 O	when	al Home
Physician	\dashv	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca	ardiac or respiratory	arrest, shock	tue, E	Approximate Interval
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Hanging				Between Onset and Death
, as		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.				
	ji	if any, leading to immediate cause. Enter Underlying Cause				
xecuted n and - transit	Wedical Examiner	events resulting in death) Last Due to (or as a consequence of): d.				
60, ate be execu hysician and e burial - tra	dical	UNPENDED X AMENDED #1, per me, g934 12-14-12 sm				
760, ficate b g physic s the bur	/Me	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic	pregnancy		Date of delivery	
D.O. Box 6876 that the death certificate need by the attending phy detached for use as the	Physician/	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	pregnancy	.	Ontil E	ay Year
). BC the dez by the z	Phys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Par	rt I. 23e. D	id tobacco us	e contribute to	he cause of death?
, P.O. res that the signed by be detach	d by			Yes 2	No 3 Prob	ably 4 Unknown
of Vital Records, ng Physician: The law require After this certificate has been si meral director, page 2 should b	Completed			utopsy	prior to c	opsy findings available ompletion of cause of
tal Reco	B			erformed? es 2 No	death? 1 ✓ Ye	s 2 No
Vital Rec ysician: The his certificate director, page	æ	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other,4	Check only one) Nursing Home 5	Residenc	e 6 🗸 Other	Scene
n of V ding Phy After thi funeral d	은	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Descr	be how injury	occurred	COOLIG
Division tal or Attendi rs after death. al Director: /	atio	1 Natural 5 Pending PoUND: Pound P	No ,	nanged sel		
Division spital or Attenchours after death nueral Director:	Certification:	3 ✓ Suicide 6 Could not be determined (Specify) Jail/Penal		on (Street and n, State) y Avenue, T		ral Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical C	29a. Certifier (Check only one) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place one) 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place one)	ce, and due to the	ause(s) and r	manner as state	
1	Me	29b. Signature and title of certifier 29c. License number			te signed (Mor	
		O.C.M.E.		Dece	mber 8, 201	2
30/		Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, I	Baltimore, M D	21223		
S Regis	ate	31. Date filed (Month, Day, Year) DEC 1 4 2012 Registrar's Signature A. Aparkar	·			
Negis	arell	HEL 17 CUIG / BARRIED No. 19		4.156		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ TUNCE Medical 4a. Facility Name (if not institution, give street and number) 4.34
BALTI MORD WASHOWY ME **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORQ U MEdICALLHE GLEN NNL- ARUNG Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs, 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) Director 1**√** M 2 □ F 30 or 28a-f shov 10a. State 10b. County event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 Yes 2 □ No 10g. Citizen of What Country? 230 21076 or iteme . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status . Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Pyes 2 If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Divorced "naturei" 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
TRANSPORTATION OPERATOR 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) Unk permit. Page 1 and 2 should be.
Depertment of Health and Mental Important: If item 27 is ment injury or other. မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): To the Hospitel or Attending Physicien: The lew requires that the deeth certificete be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlan-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No
9 Unknown Month Day 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIABBTES NEWTUS TYPEO2 Division of Vital Records, 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 1 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Medical Certificate: 27. Manneyrof Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 Yes 2 No 5 Pending Investigation 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 3 who completed cause of death (Item 23a) (Type, Print) 1028 RITCHIE HWY, SUITE 134

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Marylar	nd / Depa	artment of F tificate of D	eaith and iv		giene 2017 Reg. No.	2 40577
	Physicia Medic		Decedent's Name (First, Middle, Last) Helen Dorothy Hy					2. Date of Dear	Daws - Voor	3. Time of Death
	Examir		4a. Facility Name (if not institution, give s	treet and number)			Location of Death		4c. County of Dea	George's
	Funeral		Doctor's Community 5. Social Security Number 6. Sex		last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. B	rthplace (State or Foreign
ļ.	Director		520-26-8982 1 Usual Residence of Decedent	M 2 🖾 F 85	Yrs.	World Baye	110010	Oct 3,		yoming
	iryland a-f sho	ctor	10a. State 10b. County		ty, Town or Lo					10d. Inside City Limits
	the Ma or 288	Dire	MD Prince Go 10e. Street and Number	eorge's		Greenbe	It		10g. Citizen of What C	1 🔀 Yes 2 🗌 No ountry?
	th with ns 23a must b	Funeral Director	101 Ridge Road			207			United St	ates
21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced	 12. Was Decedent Ever in U.: Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates. 	If	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: Wh	
15-0	72 hou n "natı Aedica	Completed	15. Decedent's Edu (Specify only highest grad		(Give k	ent's Usual Occupa	ation Juring most of working	ng	16b. Kind of Business	s/Industry
212	within giene. eer tha		Elementary/Secondary (0-12)	College (1-4 or 5+)	Homer	NOT use retired) naker			Own Home	
Maryland	ould be filed within 7: d Mental Hygiene. marked other than matic event, the M6	To Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, M	,	
ary	should I and Me is marl		Richard Haaq 19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailin	g Address (Street a			City or Town, State, Z	ip Code)
	I and 2 should be file Health and Mental H tem 27 is marked o other traumatic even		Lloyd L. Hysell			Ridge Rd.		elt, MD	-	
mor	Page 1 ment of I ant: If its ury or of		1 ☐ Burial 2 X Cremation 3 ☐ F 4 ☐ Dogation 5 ☐ Other (Specify)	Removal from State	-	atory or other place	tory 12/1		20c. Location - City o	
Baltimore,	permit. Page 1 a Department of H Important: If ite any injury or oth		21. Sign were of Funeral Service	1 1/2	²² GC	Name and Address	s of Facility Cremation	n Servi	ce P.O. Box	
		П	33a. Part 1. Enter the disease, or complishock, or heart failure. List only one							Approximate Interval Between
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ	n Àg					Onset and Death
	Examiner	L	Sequentially list conditions,	Due to (or as a consequ	derice oij.					
	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	uence of):					
	icate be executed ip physician and is the burial-transit		that initiated events cresulting in death) Last	Due to (or as a consequ	uence of):		·			
200	cate be physic s the bu	edical	d							
89 ×	ath certifice attending p	an/M	ZOD. Was decedent pregnant	Bc. If yes, outcome of pregna		Ectonic pregnancy	,		23d. Date of de	elivery
O. Box	that the death certificate be executed ned by the attending physician and e detached for use as the burial-transi	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of c		Other (specify)			Month	Day Year
	တို့ မြောက်	þ	Part II. Other significant conditions con	ributing to death but not res	sulting in the ur	nderlying cause give	en in Part I.		oacco use contribute t es 2 □ No 3 □ F	o the cause of death? Probably 4 Unknown
Division of Vital Records,	has has	Completed						24a. Was ar autops perforn 1 \(\subseteq \text{Yes} \) 2	prior to death?	utopsy findings available completion of cause of
ta	ilcian: The certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:		100	ce of Death (Check		Z NO TO TE	S Z LINO
ot V	g Phys er this o	e: To	27. Manner of Death	1 ☑ Inpatient 2 ☐ 28a. Date of injury	28b. Time of	28c, Injury	at Nursing Hor		nce 6 Other (Spec	cify)
lon	tending death. tor, Aft the fur	ertificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day, Year)	injury 		yes 2 □ No			
DIVIS	al or A	O	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		et, factory, office	2	28f. Location (Str City or Town,	reet and Number or Ru , State)	ıral Route Number,
	To the Hospital or Attending Physiciam: within 24 hours after death. To the Funeral Director, After this certific completely filled in by the funeral director,	Medical	(Check 2 \(\subseteq Medical Examine	ian: To the best of my knowler: On the basis of examination Practitioner: To the best of n	n and/or investi	gation, in my opinior	n, death occurred at f	the time, date and	d place, and due to the	cause(s) and manner stated.
	With Congression		29b. Signature and title of certifier	~	_	29c. License	number	29	9d. Date signed (Mont	h, Day, Year)
	10V	}	30. Name and address of person who con	npleted cause of death (Item 31.8 32. Registrary Signat	23a) (Type, Pr	int)			4-10-	ouic
			IVAN ZAMA	ND. 8118	6000	heick	Rd., ho	anhan	n, MDo à	20706
	Stat Registra	e ir	DEC 1 4 2012	en Megistraty Signat	arke		,			

Hysell, Helen

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2:36 December 2012 Рм Kimberly Winston Haffner Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 16000 Pond Meadow Lane Bowie Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth . Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min (Month, Day, Year) Director 216-64-1646 1 M 2 X F Oct 19, 1952 Virginia 60 filed within 72 hours after death with the Maryland al Hygiana. al Hygiana. d other than "natural", or itams 23a or 28a-f shov 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or than "natural", or itams 23a or 28a-f sho Director 1 Yes 2 X No Upper Marlboro Prince George's 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20772 8801 Frank Tippett Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛛 No Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Equine 11 Groom Manager permit. Page 1 and 2 should be filed Department of Health and Mental Hy, important: if item 27 is marked othe any injury or other traumests Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Winston Joseph Boyd Hunt Lois Turpin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bradford / Daughter 16000 Pond Meadow Ln. Bowie, MD 20716 BreeKera 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State inal Journey Crematory 12/14/2012 4 Donation 5 Other (Specify) Woodbine, Maryland 21. Signature of Funeral Service Ligana Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 3a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition 2 peens Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate educe. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) igned by the attending physician and be detached for use as the burlal-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown To the Hospital or Attending Physicien: The law require within 42 hours after death.

To the Funeral Director, After this certificate has been si completely filled in by the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 1 🗌 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 **1**00 Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 | 3 | (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cortifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of cert 29c. License number 30. Name and address of person who use of death (Item 23a) (Type, Print) ARLE 12en 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 40579 Reg. No 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 8 2012 William Wylie Hopkins Jr. 9:30 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Rock Spring Village Forest Hill Harford 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Director 213-16-4126 1 ፟፟ M 2 □ F Apr. 16, 1921 Maryland 91 Usual Residence of Decedent or 28e-f show filed within 72 hours after death with the Maryland at Hygiene. 1 other then "naturel", or Items 23a or 28e-f shov 10a. State 10b. County 10c. City, Town or Location the Medical Evaniner must be notified at 10d. Inside City Limits Director 1 Yes 2 X No Marvland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 1407 Rolling Place 21014 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 end 2 should be filed wit Department of Health and Mental Hygier Importent: If Item 27 is marked other t. any injury or other traumatic event, the once. Insurance Company Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Annabel (nmn) Webb William Wylie Hopkins Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1407 Rolling Place, Bel Air, Maryland 21014 Robin C. Hopkins / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c Location - City or Town State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Darlington Cemetery 12-15-2012 Darlington, Maryland 21. Signature Funeral Service Licenses 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) en o stare Dementin Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician end for use es the burial-transit Exam Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 b Hospital or Attending Physician: The lew requires that the deeth certificete 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicians. IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) Pregnant at time of death Month Day cate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 1+BP 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autoosv CAD 1 ☐ Yes 2 No ☐ Yes To the Hospital or Attending Physician: "within 24 hours after death.

To the Funerel Director: After this certific: completely filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Assisted 2 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Living 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, gearn occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 032217 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bel Air, MD 21014 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40580 State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December William 2012 E. Horn 5:32 a. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gilchrist Towson Baltimore 8. Date of Birth (Month, Day Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Director 284-24-2983 1 X M 2 D F 84 1928 Ohio 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 V No Maryland Baltimore Phoenix 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Thorndvke Garth 21131 U.S.A. 12. Was Decedent Ever in U.S.
Armed Forces?
1 ∑ Yes 2 □ No
If Yes, Give
Year or Dates. Air Force Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Research Engineer Westinghouse Defense Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Milton Horn Ethel Henderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pege 1 and 2 sh Depertment of Health er Importent: If item 27 is any injury or other trau David C. Mahoney / Son 14 Overshot Court Phoenix. Maryland 21131 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Garrison Forest Cem. 12/19/2012 Owings Mills, Md. 4 Donation 5 Other (Specify) 21. Signature of Firm of Service Lenses 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 a 23a. Part 1. Enter the disease, or optications that caused shock, or heart failure. List no one cause on each line. plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ DAUG disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ulsease or injury that initiated events Due to (or as a consequence of) burlel-transit or Attending Physician; The law requires that the death certificate be executed and Exa resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the bule Physician/Medical Box 68760 IF FEMALE If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Month Vear 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 (No 1 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident work? 1 ☐ Yes 2 ☐ No 5 Pending М Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatu and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2017 dress of person who completed cause of death (Item 23a) (Type, Print) Clarks AARON 31. Date filed (Month, Day, Year) State 4 201 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 40581 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month DECEMBER SUE B. HALLEY Day 2012 1:20 A.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE TOWSON GILCHRIST CENTER If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Country) Director 219-32-3194 1 M 2 K F 10/30/1934 WASHINGTON, DC Vrs 78 28a-f show th and Mental Hygiana. 27 is merked other than "netural", or items 23e or 28e-1 shot traumetic event, the Medical Evaminar must be notified at within 72 hours after deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No LUTHERVILLE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral APT. 354 21093 2525 POT SPRINGS ROAD 12. Was Decedent Ever in U.S. Armed Forces?, 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 2 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: 3 ☒ Widowed 4 ☐ Divorced Completed WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) YEARS ADMINISTRATOR SCHOOL Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental of Health and Mental fitem 27 is merked rother traumetic ev ပ္ SUSIE MATHEWS HUGH BURKINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 800 BRIERGREEN CT. BEL AIR. MD THOMAS J. HALLEY, III/SON Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Paga 1 e Depertment of h Important: If ite sny injury or ott once. 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/12/2012 CATONSVILLE, MD METRO CREMATORY, INC. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JOHNSON-FOSBRINK FUNERAL HOME, P. A. MO0217 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ disease or condition ow umma Medical resulting in death) to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uissase or injury that initiated events Examine Due to (or as a consequence of) ettanding physicien and if for usa es tha buriai-transit The law requires that the daeth cartificete be exacuted Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day signed by the et id be datached fo 9 | Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? হ Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed cartificata hes baen si irector, page 2 shouid 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: I within 24 hours eftar death.

To the Funeral Director: Aftar this cartifics complately filled in by the funeral director, I of Vital 8 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 🗌 Yes 2 12 No <u>م</u>| 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 A Natural 5 Pending injury Division 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a. Certifie to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature, and title of certifie 30. Name and indress of person who completed cause of death (Item 23a) (Type, Print) warls ST TOUSON MO N. 701 31. Date filed (Month, Day, Year) 3. Registrar's Signature

DHMH 17 Rev 06-2011

State

Registrar

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12-08910 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Karjia Jiang 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ Month Day November 23, 2012 1040 hrs Ka ia Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bethesda Montgomery Suburban Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year **Funeral** 5. Social Security Number Foreign Country) Months Days Hours Min 602-95-4192 Director 1 M 2**X** F Usual Residence of Decedent 10d. Inside City Limits any 10a. State City, Town or Location 10b. County 1 Yes 2 No with the Maryland Director 10g. Citizen of What Country 10e. Street and Number 22066 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 12 Was Decedent Ever in U.S. 14. Race - American Indian, 8lack 11. Marital Status Armed Forces? hours after death 1 Never Married 2 Married Yes Sian Yes 2 No specify: f Yes, Give Year Specify: 3 Widowed Divorce ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DD NDT use retired) Guangxi Medical Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene.
Important: If item 27 is marked other that injury or other traumatic event, the Medica lechnician Inivers. 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname Be Signo inhe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Great Falls V Sterlina ue Dr Sheng ontas 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 2 Burial 2 Cremation 3 201 sem Inc Donation 5 Dther Specify 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility (NO1585 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. /Medical Death aDrowning Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Dieuaeu or injury that i Due to (or as a consequence of): events resulting in death) Last andtransit AMENDED# 1 as noted, per me, g934 12-18-12 sm ician/Medical X UNPENDED attending physician or use as the burial -: Hospital or Attending Physician: The law requires that the death certificate be a 24 hours after death.
? Puneral Director: After this certificate has been signed by the attending physicia rely filled in by the funeral director, page 2 should be detached for use as the buria 3a,27,28a-f,per me,g935 Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? 4 Pregnant at time of death 5 Other (Specify) Physic 1 Yes 2 V No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? ✓ Yes 2 No Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? Nursing Home 5 Residence 6 Other 1 🗸 Yes 27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural subject drowned 1 Yes 2 X No 5 Pending fd 11-23-12 fd: 9:00am Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Potomac River below Rocky Island Great Falls, MD. 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be Suicide determined (Specify) found in river Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

To the 1 within 2 To the 1 State

2 🗸

29b. Signature and title of certifier

Jack Titus MD.

and manner stated.

32. Registra s Sigr

30. Name and address of person who completed cause of death (Item 23a)

DHMH 17 Rev 1/2001 OCME 2006

Registrar

Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

November 24, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar . Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician/ Mil Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bactimore Works susde 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 5 Funeral Hours 85 Director 1 M 2XXF 9/29/27 Yrs NC ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director Randallstown Baltimore MD 1 Yes 2 No 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 21133 4023 Huntshire Road Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. 11. Marital Status Black, White, etc à 1 Never Married 2 Married 1 Yes 2 XXO
If Yes, Give
Year or Dates. Black Maryland 21215-0036 within 72 hours after 1 Yes 2 Kino Specify: 3XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72 in and Mental Hygiene.
7 is marked other than "n Elementary/Secondary (0-12) College (1-4 or 5+) Room Attendant Hotel 8 0 Be 18. Mother's Name (First, Middle, Maiden Surname)
Alice Saunders 17. Father's Name (First, Middle, Last) ဂ္ Unk 1 and 2 should b of Heelth and Mer item 27 is mark other traumatio 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1900 Albemarle Road, Apt C6 Brooklyn NY 11226 Jacquelin Bhola Daughte Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Page 1 a
Depertment of F
Important: If ite
eny Injury or ot Rosehill Cemetery 1 Burial 2 Cremation Removal from State 12/15/12 Linden NJ 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Victor Doda 22. Name and Address of Facility Charles L. Stevens Funeral Home, 1 1501 F. Fort Avenue, Baltimore MD 100 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Ruptured Onset and Death Immediate Cause (Final disease or condition day Physician/ Medical resulting in death) Due to (or as a consequence of) Éxaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burlal-transit Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires thet the deeth certificate be executed Due to (or as a consequence of): 24 hours after death.

24 hours after death.

9 Funeral Director: After this certificate has been signed by the attending physician Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Fetopic pregnancy in the past 12 months? Month Day 5 Other (specify) 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29c. License number 29d. Date signed (Month, Day, Year) D00562 Son who completed cause of death (Item 23a) (Type, Print) 30. Name and address of

DHMH 17 Rev 06-2011

State

Registrar

Gardie

31. Date filed (Month, Day, Year,

32. Regist

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#45, c. perPHYS#10b, c. perFH, G934, I2/14/2012, WS
State of Maryland / Department of Health and Mental Hygiene

		•	1 - For State Registrar Cer	tificate of Death	,	Reg. No.	locol.
П	Physicia	n/	Decedent's Name (First, Middle, Last) VITA MARIE KENCEL		2. Date of Dea	1 ^{Day} 2012 ^{Year}	3. Time of Beam
in the same	Medic Examin	al	4a. Facility Name (if not institution, give street and number)	4b. City. Town, or Location of Death			11:05A M
-) LABIIIII	C1	606 Dearbrook Rd.	4b. City. Town, or Location of Death Bel Air Baltimore Count	V	4c. County of Dea Hari Balt	ord
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birl (Month, Da	th g Bi	rthplace (State or Foreign ountry)
	Director		218-46-2476 1 □ M 2XXF 65 Yrs.		Mar. 12	2,1947	ОН.
	f shoved at	tor	Usual Residence of Decedent 10a. State 10b. County Harford Morry Load	Bel Air			10d. Inside City Limits
	e Mar r 28a- notifie	Director	Maryland Baltimore	Baltimore Count	y	40-011	1 Yes 2 No
	with th	erall	606 Dearbrook Rd.	21014		10g. Citizen of What C	
	items	Funeral		Vas Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Am	erican Indian,
21215-0036	nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at e	ted by	I 1 □ Never Married 2 □ Married I 1 Yes 20 X No I	Yes 2 No Specify:	7,1041,1010.7		White
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	To the Hospital or Atte within 24 hours after de To the Funeral Director completely filled in by the	Medical	29a. Certifier (Check only one) 1	igation, in my opinion, death occurred	at the time, date a	and place, and due to the	cause(s) and manner stated.
	To the within To the complete		29b. Signature and title of certifier	29c. License number	827	29d. Date signed (Mont	th, Day, Year)
	1		30. Name and address of person who completed cause of death (Item 23a) (Type, P	DEUGS,	Ba	Our m	1) 21014
	Stat	e	31. Date filed (Mogith, Day, Year) 32. Registrar's Signature	way touch by	1/20	- 001. 10	2 - 01/

DHMH 17 Rev 06-2011

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December ng. 2012 :30 AM Norwood Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Oak Lodge Anne Arundel Pasadena 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Feb. 13 1931 216-30-7035 Days Director 1 XM 2 □ F MD Usual Residence of Deced 1 and 2 should be filed within 72 hours efter death with the Maryland of Health and Mental Hygiene. item 27 is marked other then "natural", or items 23a or 28e-f show other traumetic event, the Medical Execution must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel 1 Yes 2 XNo Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3 Seaborne Drive 21122 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. ò 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes. Give White 3 🗆 Widowed 4 🗆 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Horticulturist Gardening Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဨ Clarence King Ester McGuigan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arthur King (brother) <u> 3 Seaborne Drive, Pasadena, MD 21122</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of I
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eny injury or ot
once. Druid Ridge Cemetery 20 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 23a. Part 1 Enter the lisease, or comiliar ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fair ie. List only one pluse on each line. Approximate Interval Between Onset and Death himsely Immediate Cause (Final Physician/ Myocardia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Vear Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown cate has been sig ourents. 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 🗌 No ☐ Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) , 2 🖼 No Other: 4 Nursing Home 5 Residence 6 Pother (Specify) 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funera Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number D£2544 Vec 10, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOD CTEIPE Rd #204A, Catensville, 41021228 m.D. State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 40586 State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No. Registrar Physician/ 1. Decedent's Name (First, Middle Last) 2. Date of Death 1510 hrs Medical Examiner December 10, 2012 Kevin L. Knauff 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 902 Race Road **Baltimore County** 5. Social Security Number 6. Sex If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) If Under 1 Year **Funeral** Months Days Hours Director 11/22/1963 49 Country) MD 217-82-1868 1 X M 2 F Usual Residence of Decedent 10a. State 10d. Inside City Limits 10c. City, Town or Location MD Baltimore Essex 1 Yes 2 K No hours after death with the Maryland rector 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 902 Race Road 21221 USA 23a Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14 Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 1 Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: White 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If item 27 is marked other than ", iojury or other traumatic event, the Medical E. Baltimore, MD 21215-0036 Arundel Corp. 12th Mechanic 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) å Paul Knauff Sr. Mathilda Hengemihle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 2 1 9 19a. Informant's Name/Relationship (Type, Print) Brenda Marr (sister) Whiteway Road. Sparrows Point, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State crematory or other place) 12/17/12 Baltimore, MD Bayview Crematory 4 Donation 5 Other Specify. 21. Signature of Faneral Service Licenses 22. Name and Address of Facility300 Mace Ave. Baltimore, MD Connelly Funeral Home of Essex Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line een Onset and /Madieni Death a. Hypertensive Cardiovascular Disease **Examine** or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Atteoding Physiciae: The law requires that the death certificate be executed within 24 hours after death.

To the Fuoeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Physician/Medical AMENDED 23a, pt. II, 27, per me, g934 12-18-12 sm X UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Day Year 2 _ past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 ✔ Unknown chronic obstructive pulmonary disease, diabetes mellitus Completed 24a. Was an 24b. Were autopsy findings available morbid obesity autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 DOA ٥ 1 Yes 2 No 28a. Date of Injury (Month, Dey, Yeer) 27, Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 1 Yes 2 No 5 Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street end Number or Rural Route Number, City 3 Could not be Suicide determined Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

31. Date fi State Registrar

32. Registrar's Signature

and manner stated

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

29d. Date signed (Month, Day, Year)

December 11, 2012

29b. Signature and title of certifier

Melissa Brassell, MD

LP 4 2012

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44		30. Name and address of person who complete	ed cause of death (Item 23a)							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ December 07 2012 02:40 Lewandowski Robert Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Tate Hospice House Linthicum Heights Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Month, Day, Year)
July 28 1941 Hours Min. 217-40-8537 1 🛛 M 2 🗆 F Director 71 Yrs MD ms 23a or 28a-f show must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Pasadena Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ural", or items 23a o | Examiner must be Funeral USA 21122 1217 Holmewood Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) old be filed within 7. Mental Hygiene. other than College (1-4 or 5+) Flementary/Secondary (0-12) Law Enforcement 12 Police Captain Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Thaddeus Lewandowski Anna Kemp should I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1217 Holmewood Drive, Pasadena, MD 21122 Patricia J. Lewandowski (spouse) other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Page 1 a Department of H Important: If ite any injury or ot Dec. 2012 1 X Burial 2 Cremation 3 Removal from State Maryland Veterans Cem 4 Donation 5 Other (Specify) Crownsville, Maryland Signature of Funeral Service License 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Pa 1. Enter the disease, compl. ations that caus shock, or heart failure. List only cause on each line o not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final Physician/ ore Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transit Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 ate has been signed by the attending phys page 2 should be detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy Colon Caners death? tastatic certificate 2 1\No 1 Yes Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Division of Vital Hospital 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 110501 ျှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural Natural 5 Pending 2 Accident 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signa 29c. License number cause of death (Item 23a) (Type, Print) 30. Name and address of person SSEV 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40589 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month DECEMBER 11 2012 RICHARD LEBOWITZ 09:04PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY GENERAL HOSPITAL OLNEY MONTGOMERY 5. Social Security Number If Under 24 Hrs. Hours Min. **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign Days (Month, Day, Year) Director 212-44-6534 1 X M 2 □ F 67 07/13/1945 MD Usual Residence of Decedi r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 Yes 2 No MONTGOMERY BROOKEVILLE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 18649 OUEEN ELIZABETH DRIVE 20833 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? δ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: WHITE Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed wift Department of Health and Mental Hygien Importent: If Item 27 Is marked other ti and hijury or other traumatic event, the any hijury or other traumatic event, the angles. MANUFACTURING SALES Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ IRVIN LEBOWITZ MOLLIE POLSKY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HARRIET LEBOWITZ / WIFE 18649 QUEEN ELIZABETH DRIVE, BROOKEVILLE, MD 20833 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) HILLTOP SERVICE CORP. 12/13/2012 TOWSON, MD 21. Signature of Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the ettending physician and ched for use as the burial-transit e Hospital or Attending Physicien: The law requires that the death certificate be executed 24 hours after death.

24 hours after death.

9 Funeral Director: After this certificate has been signed by the ettending physician and leitely filled in by the furnaral director, page 2 should be detached for use as the burnal-transit Exam that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 🗌 No 1 🗌 Yes 25. Was case referred to ical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital: Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year, 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie To the within 2
To the F Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Sign

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

no completed cause of death (Item 23a) (Type, Print)

32: Registrar's Si

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Departr	nent of Health and Me		12 40590
			Registrar 1. Decedent's Name (First, Middle, Last)		Reg. No. Date of Death	3. Time of Death
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^ , E	Medic xamin			City, Town, or Location of Death	4c. County of	Death
_ / بـ			0	atonsville	Baltimo	re
	uneral		1 DM 2 FF 90	Under 1 Year If Under 24 Hrs. 8. nths Days Hours Min.	Date of Birth (Month, Day, Year) 1922 N	9. Birthplace (State or Foreign Country) 1ary Land
	rector		215-18-7135 Tusual Residence of Decedent	14 1	oril 28, 1922 N	laryland
and	show	ō	10a. State 10b. County 10c. City, Town or Locatio	n		10d. Inside City Limits
Maryl	8a-f tiffied	rect	Maryland Baltimore Catonsville			1 ☐ Yes 2 🔀 No
the	a or 2 be no	Ö	10e. Street and Number	Of. Zip Code	10g. Citizen of Wh	
nd Z1Z13-UU36 filed within 72 hours after death with the Maryland al Hygiene.	ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	JII ST III A	1228	United St	
deat	r iter iner		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Never Married 2 ☐ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ⚠ No	Decedent of Hispanic Origin? (Specify , specify Cuban, Mexican, Puerto Ric	y Yes or No- an, etc.) 14. Race - Black,	American Indian, White, etc.
affe a	al", o Exam	d by	3 X Widowed 4 □ Divorced 1 □ Yes 2 ∧ No 1 □ 1 □ 1 □ 1 □ 1 □ 1 □ 1 □ 1 □ 1 □ 1	Yes 2X No Specify:	Specify:	White
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Maryland 2 should be filed th and Mental Hy	ed of	일	17. Father's Name (First, Middle, Last) John F. Kunke1	18. Mother's Name (F. Lillie Anr	irst, Middle, Maiden Surname) n Geist	
Marylan should be fil and Mental	27 is marke traumatic			ddress (Street and Number or Rural Ro		te Zin Codel
	C 42			ensgate Road, Bal	Ltimore, Marylar	id 21229
			20a. Method of Disposition 20b. Place of Disposition 20b. Place of Disposition cemetery, cremator	n (Name of Date	e 20c. Location - C	ity or Town, State
Page	ant: If		4 Ponation 5 Other (Specify) Atlantic Cr	ematory Dec.13,	,2012 Glen Burn	
Saltimo permit. Page Department	Important: If if any injury or o once.			me and Address of Facility AMBRO		
11 % Å	드 등 의		TOTAL CONTRACTOR OF THE PARTY O	8 Sulphur Spring		ryland 21227
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.			Approximate Interval Between
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VITAI	ertifica ctor, p	Be (25. Was case referred to medical examiner?	26. Place of Death (Check on		
hysic	this coal dire	၉	1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3		5 Residence 6 Other	Specify)
n OT	After	Certificate:	27. Manner of Death 1 Natural 5 Pending 28a. Date of injury (Month, Day, Year) 28b. Time of injury	28c. Injury at work? 1 □ Yes 2 □ No	Describe how injury occurred	
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DIVISION tal or Attendii s after death.	d in b		4 Homicide determined building, etc. (Specify)	,,	City or Town, State)	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	unera	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occur	red at the time, date and place, and d	ue to the cause(s) and manner	as stated.
the H	the Fu	Med	(Check 2 ☐ Medical Examiner: On the basis of examination and/or investigationly one) 3 ☐ Certifying Nurse Practioner: To the best of my knowledge, death			
Vitt	2000		29b. Signature and title of certifier ATTENDING	29c. License number	29d. Date signed (i	
	lo.		Physicians	D16700	DECEMB	EK 10, 2012
	3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. H. M. MACHIRAW 720-C M	DIB200	e Go Car	NSUILL 2000
C L	Stat	e.	31. Date filed (Month, Day, Year) 32. Registra's Signature	HOVER CHOICE	- IT CHI	11-11/18 2120
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5, per fh, g934 12-28-12 sm
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 10:40 PM Za 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cheverly m Prince George's George's Hospital Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Days Hours (Month, Day, Year) 579-24-Director 1 M 2 XF 96 Feb. 7, 1916 Ohio Usual Residence of Deced ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director MD 1 X Yes 2 No Prince George's Mitchellville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10450 Lottsford Rd. 20721 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Was Deceuent ____ Armed Forces? 1 ☐ Yes 2 📈 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed wit. Department of Health and Mental Hygier Important: If item 27 is marked other ti any injury or other traumatic event, the once. 4 Unknown Unknown Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Miller Jacob Frances Henrietta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4910 Massachusetts Ave. NW #215, Washington DC 20016 Richard Mayfield / Attorney 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Chesapeake Crematory 12/13/2012 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Signatore of Funeral Service Licensee M00382 22. Name and Address of Facility Rapp Funeral and Cremation Services tisle & Lohman 933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PUlmonary OBSTRUCTUR Chronic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for sele consequence of use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an After this certificate has I autopsy performed? Yes 2 🔀 No completely filled in by the funeral director, 25. Was case referred to medical 8 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 🖾 ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State 24 hours a Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated \(\begin{align*} \begin{align*} \lefta \lefta \lefta \lefta \lefta \text{death occurred} \\ \text{at the time, date and place, and due to the cause(s) and manner as stated. \end{align*} (Check To the within 2 To the F only one) 29b. Signature a title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MI ss of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State an Ros Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 40592 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 12^{Year} Month 2 Physician/ MUHLY VIRGINIA FRANK 1817 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner nearth pper chesadeake BelAir Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Director 213-20-3416 Usual Residence of Dece 1 □ M 2 🎗 F 10/24/1923 Maryland iral", or items 23a or 28a∙f show Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State Director 1 Yes 2X No Jarrettsville Harford 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 21084 3909 Eaton Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaking Be 18. Mother's Name (First, Middle, Maiden Surname) # 17. Father's Name (First, Middle, Last) Mental 1 and 2 should be fill of Health and Mental item 27 Is marked 2 Katherine Louise Furst John William Frank 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) <u> 3909 Eaton Drive - Jarrettsville, Maryland</u> William M. Muhly (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If its
any Injury or ot 1 Durial 2 Cremation 3 Removal from State Baltimore Cemetery 12/14/2012 | Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. Dusten Brown 21087 11750 Belair Road - Kingsville, Maryland Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition ISC MEMIC INJUSTICE Extensive Physician/ Medical resulting in death) Due to (or as a consequence of): tral thorlation. Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence or) Examine Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Myocardiae infanction. 1 ☐ Yes 2 ☐ No 3 💢 Probably 4 ☐ Unknown , UTE Aute an Chame Ecoli bactérerie 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No Kidydiscon (COPT) 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral a 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in multiplication in multiplicat Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 12-11-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HAFSA BHATTE VPPER CHESAPEAKE HOSPITAL

₩HMH 17 Rev 06-2011

State

Registrar

HAFSA BHATTE

DEC 1 4 2012

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 20¹2 Bernardine Mary McCubbin December 5:00 P.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Stella Maris Towson Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days Hours 219-28-7616 Director 1 M 2 X F 84 May 17, 1928 Maryland permit. Page 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mexical Examiner must be notified at. 10d. Inside City Limits 10b. Count 10c. City, Town or Location 10a. State Director 1 Yes 2 No Baltimore West Edmondale 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 5535 Channing Road 21229 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritai Status 12. Was Decedent Ever in U.S Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give þ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify. 3 ☒ Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ 2012 James Edward Jacobi Bernardine Marie Yakel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Patrick McCubbin 234 Maple Avenue: Baltimore, 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State DECEMBER 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Lake View Mem. Park 12/14/12 4 Donation 5 Other (Specify) Sykesville, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Servic Licenses 1630 Edmondson Catonsvill Avenue: 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician COLON CANCER Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the attending physician and ched for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical certificate be BERNADINE McCUBBIN IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Hospital or Attending Physician: The law requires that the death Month Day Year Pregnant at time of death Yes 2 X No detached 9 Unknown 9 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detac Part II. **Other significant conditions** contributing to death but not resulting in the underlyi<mark>n</mark>g cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) **Division of Vital** Be Other: 4 \square Nursing Home 5 \square Residence 6 \blacksquare Other (Specify) HOSPICE 1 🗌 Yes 2 X No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred Certificate: X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🕱 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 20

State Registrar

DHMH 17 Rev 06-2011

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

JONES,

31. Date filed (Month, Day, Year)

CRNP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2012 40594

	F	Registrar	cate of Death	Reg.		. 1005				
Physicia Medical Examin	n/	1. Decedent's Name (First, Middle,Last) Willie McKnight, Jr.		Date of Death Month December 1	o, 2012	3. Time of Death 0715 hrs				
		4a. Facility Name (if not institution, give street and number) 2001 N Hilton Street	4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A					
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last b	irthday) If Under 1 Year If Under 24Hrs Months Days Hours Min		MM/DD/YYYY) 9. Birth Foreign Cour					
e Maryland or 28a-f show aoy fied at ooce.	5	10e. Street and Number	imore	10g	. Citizen of What Counti	1 Yes 2 No				
r death with th or items 23a must be ootil	by Funeral	2001 N. Hilton St. 11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced of Pates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	21216 13. Was Decedent of Hispanic Origin? (Silf Yes, specify Cuban, Mexican, Puerto 1 Yes 2 X No specify: a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret	Rican, etc.)	USA 14. Race - America White, etc. African Specify.Amer 6b. Kind of Business/Inc US Gov t					
MD 21215-0036 a.2 should be filed within 72 hours after the and Mental Hygiene. a.27 is marked other than "matural", turn the Medical Examiner to work, the Medical Examine.	Be Completed	12 17. Father's Name (First, Middle, Last) Willie McKnight	unk	First, Middle, Ma	iden Surname)					
■ マヨョョ	٩	Vondell S. McKnight/Sister 20a. Method of Disposition 20b. Plac	e of Disposition (Name of cemetery,	Ln #302	Owings M Oc. Location - City or T	ills,MD own, State				
Baltimore, permit. Pages I an Department of Hea Important: If ites	L	1 Burial 2 Cremation 3 Removal from State Garr 4 Donation 5 Other Specify: 21. Signature of Fun. Service Licensee.	22. Name and Address of Facilit Har 5126 Belair Rd,	-						
Physician /M dical	Ì	23a. Part / Enter the disease, or complications that caused the death. Do failure. List only one cause on each line.				Approximate Interval Between Onset and Death				
xaminer		or condition resulting in death) Due to (or as a consequence of):								
	aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last								
760, cate be executed physician and the burial - transit	/Medical Examiner	events resulting in death) Last Due to (or as a consequence or): d. UNPENDED AMENDED								
Box 68760, death certificate be he attending physicid for use as the buri	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnant 1 Live birth 4 Pregnant at time of death 9 Unknown	2 Fetal death 3 Ectopic pregnt	ancy	23d. Date of delivery Month Da	ay Year				
i, P.O. E		Part II. Other significant conditions contributing to death but not result Endstage renal disease	ting in the underlying cause given in Part I.	1	acco use contribute to the 2 No 3 Proba					
Division of Vital Records, P.O. Box 68' To the Bospital or Atteodiog Physician: The law requires that the death certiff within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Completed by			24a. Was an autopsy perform	prior to co	opsy findings available impletion of cause of				
Vital Rec ysician: The his certificate director, page	a	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER	26 Place of Death (Check /Outpatient 3 DOA Other Nursi		esidence 6 🗸 Other:	Scene				
ion of V teodiog Phy leath. tor: After th	ation: To	27. Manner of Death 1 Natural 5 Pending FOUND: FO	b. Time of Injury 28c. Injury at Work? DUND: 1 Yes 2 No 150 hrs	28d. Describe ho	w injury occurred shunt erosion					
Division ppital or Atteorous after death neral Director:	Certification:	3 Suicide 6 Could not be determined (Specify) Multi-Family A	, farm, street, factory, office building, etc. Apt.	or Town, Sta	eet and Number or Run te) treet , Baltimore, MD					
To the Hos within 24 h To the Fun completely	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or manager stated.	death occurred at the time, date and place, and or investigation, in my opinion, death occurred	d due to the cause at the time, date ar	s) and manner as stated and place, and due to the	d. cause(s)				
T W.Y.	Me	and manner stated. 29bc Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (Monitorial December 10, 20					
441	ļ		900 W. Baltimore Street, Baltimore	, MD 21223						
St Regist	ate	31. Date filed (Month, Day Year) 32. Register's Signature	<i>d</i>		-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For _ State		State of	Marylan					and M	ental H	ygieı	ne 20	12	l. 0	595
			Registrar 1. Decedent's Nam	o (First Middle	(ast)		Cer	tificate	OIL	eatn		2. Date of I		No. C U	1 6.		
п	Physicia		Leota	ie (First, iviidale	Mauersber	g						Month Nov		Day 2.012	Year	3. Time o	М.
	Medic Examin		4a. Facility Name (ii	f not institution,	give street and numbe	er)		4b. City, 1	Town, or	Location o		NOV	Z 9 T	4c. County of	of Death	1/: //-)A
manut !			Genes	is Hea	lthCare '	The P	ines	Eas	stor	า				Talb	ot		
	Funeral		5. Social Security N 266–44–6	lumber		Age (In yrs. I		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of E (Month, 1		37)	9. Birthp Count		
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	with the s 23a or ust be n	Funeral Director	10e. Street and Nu 6655 Ree		ide Road			10f. Zip	Code	216	65		10g.	. Citizen of W	hat Coun USA	try?	
Wauers	Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. snt: If item 27 is marked other than "natural", or items 23a or 28a-f sho ry or other traumatic event, the Medical Examiner must be notified at	ρ	11. Marital Status 1 ☐ Never Mari 3 ☐ Widowed		12. Was Decede Armed Force 1 ☐ Yes 2 If Yes, Give Year or Dates	es? No	'	Vas Decede f Yes, speci □ Yes 2	fy Cubar	n, Mexican	, Puerto F	cify Yes or N Rican, etc.)	0-	14. Race Black Specify:	, White, e		
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Ę.	t. Pag tment rtant: njury o		4 Donation	5 Other (S	pecify)	M∈	em. Par				12/7			Plant		y, F.	L
Bal	permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to	9	21. Signature of Fu	ineral Service L	icensee Victor	Doda	Cf 11	Name and narles 501 E.	Addres L. For	s of Facility Stev ct Av	ens l enue	Funera Balt	l H	ome, I	nc. 2123	0	
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-	Medical Examiner		resulting in death)									. 0.20				Wes	المحادي
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Box 68760	eath ce attene d for us	Physician/Me	23b. Was decedent in the past 12 1 Yes 2	months?	1 ☐ Live Bir 4 ☐ Pregna	th 2 🗌 Feta nt at time of o	al death 3 L	Ectopic p Other (spe	regnancy ecify)	у			_	23d. Date Mon		Day	Year
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Division of Vital Records,	I or At after Direc	Cert	4 Homicide	determ	ined 28e. Place of building,	injury - At no , etc. (Specif)		eet, ractory,	опісе		2	City or 7		t and Number tate)	or Hurai	Houte Num	ber,
	To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phycompleted filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2.	Medical ((Check 2	2 Medical E	Physician: To the besi xaminer: On the basis	of examination	n and/or inves	tigation, in n	ny opinio	n, death oc	curred at	the time, dat	e and pl	lace, and due	to the cau	ise(s) and m	anner stated.
	o the	Σ	only one) 3 29b. Signature and		Nurse Practioner: To	the best of m	y knowledge, o		License		апа ріасє	e, and due to		Date signed			
	->-0		Deal	Deed.	CRAP			R	093	385	78			11-20	1-1	2	
	5 m		30. Name and add	ress of person	who completed cause of	(1)		Print)	Du-	the .	M/4	ne 1	1.0	11-20	ast	on N	1601 ND
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 40596 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 Physician/ Helen Elizabeth Murphy 13 2012 A M 1:00 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death North Bethesda Montgomery Brighton Gardens . Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min. Hours 509-34-0949 Director 1 🗆 M 2 🔀 F 84 11-1-1928 Kansas Usual Residence of Decedent 28a-f shov r than "natural", or items 23a or 28a-f sho the Mealcal Examiner must be notified at 10a. State 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits MO Montgomery North Sethesda 1 Yes 2 X No ۵ 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ල within 72 hours after death with 20852 United States 5550 Tuckerman Road 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. ۾ 1 Never Married 2 Married ☐ Yes 2 🗶 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) i Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Retail Decorator of Health and Mental Hygie of Health and Mental Hygie If item 27 is marked other or other traumatic event, 世 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Keith Cool Virginia Cox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) e 1 and 2 st of Health a 9905 Harrogate Road, Bethesda, Maryland 20817 Elizabeth Sheehan Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any Injury or otl 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Arlington National Cem. Arlington, Virginia 1-21-2013 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Edward Sagel 22. Name and Address of Facility Demaine Funeral Home 520 S. Washington Street, Alexandria, Virginia 22314 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Peripheral Vascular Disease Medical resulting in death) Due to (or as a consequence of): ²Examiner Atrial Fibrillation Sequentially list conditions, if any, leading to irrimediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hypertension Hospital or Attending Physician: The law requires that the death certificate be executed physician and sthe burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 as attending I IF FEMALE use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Dav Year 5 Other (specify) ed by the a 9 Unknown 9 Unknown Division of Vital Records, P.O. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown certificate has been si lirector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 X No 1 Yes 2 No : After this certifica e funeral director, p æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 X No Other: 4 X Nursing Home 5 A Residence 6 A Other (Specify) Hospital: ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural iniury 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Continuing Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

Mahashweta 31. Date filed M nth, D y, Year) Mahashweta GHosh, MD - 14812 Physicians Lane, #161, Rockville, Maryland 20850 State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

rily and

29b. Signature and title of certified

29c. License number

030132

29d. Date signed (Month, Day, Year)

12-13-12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Robert Detember 13, 2012 3:30 a Edwin Morrow Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Stella Maris Dulaney Valley Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year **Funeral** Days Hours 218-58-3671 60 Director 1 X M 2 - F Oct. 18, 1952 Usual Residence of Decedent or than "natural", or items 23e or 28e-f show the Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Directo MD Harford Joppatown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 227 Foster Knoll Drive 21085 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Å No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) <u>Technician</u> Baltimore City Govt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frances Morrow Francis Koenigsberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 end 2 sh Department of Heath ar Importent: If item 27 is eny injury or other trau Stephanie Lee (Per. Rep.) 1070 Plaza Circle, Joppatown, MD. 21085 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Barrinore Crematory C Loudon Park 1 Durial 2 Cremation 3 Removal from State 12/17/12 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD. 21229 23a. Part 1 to the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, book, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) SEPSIS Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Discase or injury that initiated events physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as the ettending p IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Day Month 4 Pregnant at time of death 5 Other (specify) Year Yes 2 ☐ No ed by the e 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by þe cate has been sig page 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? Yes 2 K N After this certificate 1 Yes 2 No Hospital or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) **HOSPICE** မ 2 💢 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funerel Director: Af
completely filled in by the fu 2 Accider Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🔲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Tertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. Ligense number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. TRACIE L. MORGAN, CRNP TIMONIUM, MD 21093 31. Date filed (Month, Day, Year)

State Registrar

2012

DECEMBER

ROBERT MORROW

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		- For State Registrar		Ce	rtificate (of L	Death				F	Reg. No.	F- 6	, , ,	_ 1005
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ledical Examir	ner	James B. Mondshour							December 9, 2012 2332 nrs						
No. of Street,		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of						f Death			. County of				
		Anne Arundel Medical Center Annapolis										Anne Aru	ındel		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)		If Under				8. Date of B	irth (MM/	(DD/YYYY)	9. Birth Foreign	place (State or
Director		215-17-1155	1XM 2 F		33	rs.	Months	Days	Hours	Min.	04/0	01/1	979		ntry) MD
	ŀ	Usual Residence of Decedent													
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ore, ME ss 1 and 2 s of Health au If item 27 her traum	ŀ	20a. Method of Disposition	(moc		Place of Disp	oosit	ion (Name	of cem	etery,		Date 2	20c.	Location -	City or	nie 21060 Town, State
imore, MD 2121 Pages I and 2 should be fi ment of Health and Mental tant: If item 27 is marked or other traumatic event,		1 Burial 2 X Cremation	3 Removal	from State	crematory or			. T.	_	Dec.			- 7 - - 2		M77
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Baltimore, permit. Pages la Department of He Important: If ite		21. Signature of Funeral Service	Ligensee		2	2. Na	ame and A			5	tallin	ıgs I	Funer	al E	iome, P.A.
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that the d	Physician	Part II. Other significant condi			resulting in the	ne ur	nderlying c	ause gi	ven in Pa	art I.	23e. Did	tobacco	use contri	ibute to	the cause of death?
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VIS or At fter d Direct in by	Ę.		28e. Pla	ace of Injury - At	home, farm, s	tree	t, factory, o	office bu	uilding, et	tc.	28f. Location or Town		and Numb	er or Ru	ral Route Number, City
Division of options of options of the outsafter death. Terral Director: After the funeral filled in by the funeral	Certification:	4 Homicide	ermined (Specifi) Major Ro	ad / Highw	/ay				ļF.	Route 50 Ea	ast and	Rowe Blv	vd, Ann	napolis, MD
Hos 24 ho Fun		(Chook only	Physician: To the b												
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only one														
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2./		30. Name and eddress of person	n who completed ca	use of death (Ite	m 23a)	-									
31		Theodore M. King, Jr	., MD. Assis	tant Medical	Examiner	. 6	900 W. B	Baltim	ore Str	reet, Ba	Itimore, N	MD 21:	223		·
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Z Z	nd 2 sh lealth ar m 27 is her trau		Cleo Mackenney (wife) 1214 N. Curley St. Balto, Md. 21213										3 			
DCCEM	permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene, Important; if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			oosition Cremation 3 [5 Cother (Spec		State C	Place of Dispo cemetery, cren YY1SO	natory or	other plac	e) L De	_	ate 8,201		Location - C wings	-	wn, State L1s , MD
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JOSE Division	tal or Atter rs after des al Director led in by th	al Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not determined	28e. Place	of Injury - At hong, etc. (Specify		et, factor	ry, office			28f. Location City or To	(Street a	ind Number te)	or Rural	Route Number,
, 1	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in b	Medical ((Check 2			is of examinatio	n and/or invest	tigation, in	my opinic	n, death o	ccurred at	the time, date	and place	ce, and due to	o the cau	use(s) and manner stated
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	6x1.		30. Name and add	ress of person who	completed caus	e of death (Iten	n 23a) (Type, F	Print)	1/1	10	1	10 .1.	, 11	113	"	
	Star	0	31. Date filed (Mon	E JUNC th, Day, Year)	S CHINY	GOOD L	WANE	1 VA	446	414	1//	MONIL	M.	MD	U	173
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2014:25 PM December 11, Mary Jean Patterson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Rossville Rosedale Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min. Months Hours 1 □ M 2 K F 88 Yrs Director 249-18-3367 Apr 09, 1924 Ohio Usual Residence of Decedent 10d. Inside City Limits show 10b. County 10c. City. Town or Location 10a. State r than "natural", or items 23a or 28a-f shoot the Wedical Evantimes at 1 ☐ Yes 2 No Director MD Baltimore Parkville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2900 East Joppa Road 21234 United States Funeral within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. Specify: ģ White 3 Widowed 4 □ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Item 10. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Я Home Maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Basil Bonfigio Frances Cortta 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gary Patterson /Son 2900 East Joppa Road Parkville, MD 21234 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dec 15, 2012 Beltsville, Maryland Chesapeake Crematory 22. Name and Address of Facility 21. Signature of Funeral Service License MO1585 Cremation and Funeral Alternatives Keloc Keypon 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 5 tage Renal desease hd **Physician** TEAR disease or condition resulting in death) Due to (or as a consequence of /Medical Examiner Sequentially list conditions, if an leadin to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) burial-t physician Physician/Medical as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. I 1 ☐Yes 2 ☐ No detached 9 Unknown 9 Unknown isigned by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy urmed? 2 Z No this certificate of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ completely filled in by the funeral 27. Manuer of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending Parter death. After Certification: Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spec/fy) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Hospital within 24 hours a

December 12, 2012 51051 ed cause of death (Item 23a) (Type, Print) Ligen Rd, Ellicottcity, MD 21042 Month, Day, Yea
DEC 1 4 2. Registrar

29c. License number

29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 40601 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death /onth Physician/ 1:20 PM Trace December 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1 ont gomery County
9. Birthplace (State or Foreign Takoma Washington Adventist **Yark** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 6. Sex Funeral 7. Age (In yrs. last birthday, Hours Min (Month, Day, Year) Maryland 217-44-7632 Director 1 □ M 2 🗓 F 66 May 12, 1946 Washington permit. Page 1 and 2 should be filed within 72 hours efter death with the Meryland Department of Health and Mentel Hyglene. Importent: If Item 27 is merked other then "neture!", or items 23e or 28e-7 show any injury or other treumetic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Takoma Park Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7214 Trescott Ave. 20912 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) City Government 12 Clerical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Charles Ρ. Adams Mary Elizabeth Weatherall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William J. Pasko / Husband 7214 Trescott Ave., Takoma Park, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State Beltsville, MD Chesapeake Crematory 12/19/2012 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Rapp Funeral and Cremation Services
933 Gist Ave.. Silver Spring. MD 21. Signature of Euneral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Obstructive disease or condition resulting in death) chronic Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) cete hes been signed by the ettending physicien end pege 2 should be deteched for use es the buriei-trensit or Attending Physicien: The lew requires thet the deeth certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has 1 🔲 Yes 2 No Yes 2 2 To the Hoepitel or Attending Physicien: within 24 hours effer deeth.

To the Funerei Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 I DOA Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manger of Death 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work?
1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 1 Secrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and on information and only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 2017 D0067427 December 40 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue Takoma MO 600 reorge Ho 31. Date filed (Month, Day, Year) 2. Registrar's Sign State 2012 4 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Physicia Medical Exami		1. Decedent's Name (First, Middle,Last) Julie Ann Ryan				Date of Death Month November	h	3. Time of Death		
2 miles		4a. Facility Name (if not institution, give stre	et and number)	4b. City, T	Town, or Location of		4c. County of Do	eath		
Funcant		18705 Mesa Terrace #9 5. Social Security Number 6. Sex	7 And (10 yrs. 10		rstown	Odlles To Data at Dist	Washington			
Funeral Director		218-25-6018	7. Age (In yrs. Ia 2 X F 2 3	Month	er 1 Year If Under: S Days Hours	Min. 07/03/	` 1 _{E0}	Birthplace (State or or oreign Country Mary Land		
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and show any occ.		10a. State 10b. County Maryland Washington		Town or Location				10d. Inside City Limits 1 Yes 2 No		
farylan 28a-f sl	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Cour								
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5, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at gooce	Funeral		Was Decedent Ever in U.S Armed Forces?		ent of Hispanic Origin fy Cuban, Mexican, F	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ar White, et	merican Indian, Black, c.		
after d	by F.	3 Widowed 4 Divorced If Yes	ates:	1 Yes 2	No specify:		Specify: Wh	ite		
2 hours		15. Decedent's Education (Specify only hig Elementary/Secondary (0-12)	phest grade completed) College (1-4 or 5+)	16a. Decedent's Usual during most of wor	Occupation (Give kir king life. DO NOT us		16b. Kind of Busine	ss/Industry		
5-0036 filed within 72 l Hygiene. d other than ", the Medical K	Completed		4	Clerk			District	Court of MD		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical	Be Co	17. Father's Name (First, Middle, Last) Thomas H. Ryan				Name (First, Middle, N y M. Price	laiden Surname)			
212 rould be d Ment d Ment is mark	일	19a. Informant's Name/Relationship (Type, F	Print)	19b. Mailing Address		er or Rural Route Num	ber, City or Town, S	tate, Zip Code)		
MD and 2 sho salth and cm 27 is		Thomas H. Ryan/Fath		1580 Band		, Crofton,				
TOFE ages lant of He		1 Burial 2 X Cremation 3 Re	emoval from State Cr	rematory or other place) /stone Crem		12/05/2012	20c. Location - City	Pennsylvania		
Baltimore, permit. Pages 1 at Department of Hec important: If ite		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Rey	T 2.2.2.						
		michael P. Margele	-	6009 H	arford Ro	ad, Baltim	ore, Mary	apel, P.A. land'21214		
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6876 ertificat ding ph		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregn Live birth	2 Fetal death	3 Ectopic p	pregnancy	23d. Date of deli Month	very Day Year		
Box 687 e death certific the attending of for use as the	Physician/	1 Yes 2 No 9 V Unknown 9	Pregnant at time of dea	other (Spec	cify)					
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Division of Vital Records, tal or Atteoding Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	.: 	1 Natural 5 5	(Month, Day,Year)		28c. Injury at Work?	1 1	ow injury occurred ingested	drugs		
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Div spital o	Certification:	4 Homicide determined	(Specify) found	d at home		or Town, St	erstown,M	esa Terrace D.		
Division of Vital Records, P.O. Box 68760, To the Hospital or Atteoding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Medical	one) 2 Medical Examiner: On the	o the best of my knowledge ne basis of examination an	e, death occurred at the docurred in my	time, date and place opinion, death occu	e, and due to the cause irred at the time, date a	e(s) and manner as and place, and due to	stated. o the cause(s)		
To wit	Mec	29b Signature and title of certifier	manner stated.		License number		29d. Date signed (
		Potri aroni.	- Polli-		O.C.M.E.		November 30,	2012		
Ø		 Name and address of person who complete Patricia Aronica-Pollak MD. 	eted cause of death (Item 2 Assistant Medical E	,	Baltimore Stre	et, Baltimore. MD	21223			
		31. Date filed (Month, Day, Year)	32 Registrar's Signatur	Α		,				
Regist	ar	DEC 1 4 2012	enver B.	park						

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0			_ State Registrar			Cer	tificate	e of D	eath			Reg. No		2 4 (000
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7	Funeral Director		5. Social Security Number 6. Se	ex 7. Age		st birthday)	If Under Months	Days	If Under Hours	Min.	B. Date of Bir (Month, Da	ay, Year)		Birthplace (Sta Country)	te or Foreign
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	V		30. Name and address of person who	. 9	eath (Item	A m		1,1		2	VA	مناح	12.1.	212	LILA
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	1- For State Registrar	•	•	e of Death	no Mental		Reg. No. 201	2 4060		
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	4a. Facility Name (if not institution Upper Chesapeake Mo			4b. City, Town, Bel Air	or Location of De	eath	4c. County of Dea Harford	4c. County of Death Harford		
Funeral Director	5. Social Security Number 141-70-3214 6. Sex 1									
Baltimore, MD 21215-0036 bermit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 33a or 28a-f abow asy mjury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	10e. Street and Number 1900 Mont for 11. Marital Status 1 Never Married 2 Max 3 Widowed 4 Divides 15. Decedent's Education (Specific Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Norman 19a. Informant's Name/Relations	12. Was Decedent Armed Forces? 1 Yes 2 proced If Yes, Give Year or Dates: College (1-4 or 5) Last) Lyons Lyons	Ever in U.S. 1 X No 16a. De du	10f. Zip Code 21 3. Was Decedent of If Yes, specify Cut 1 Yes 2 X cedent's Usual Occurring most of working in Homemake	Hispanic Origin? Dan, Mexican, Pur No specify: pation (Give kind ife. DO NOT use 118.Mother's Not Sand1 reet and Number	(Specify Yes or Nerto Rican, etc.) of work done retired) ame (First, Middle, Ca.) or Rural Route Nu	White, etc. Specify: W 16b. Kind of Busines OWN Maiden Surname) Smit	erican Indian, Black, hite s/Industry home h		
Baltimore, MD 21215-00; pemit. Pages I and 2 should be filed with Department of Health and Mental Hygiene. Important: If item 27 is marked other tinjury or other fraumatic event, the Mex.	Karl Fric Riddlespurger-husband 1900 Montford Dr., Forest Hill, MD 2105 20a. Method of Disposition 1									
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To the Hospital within 24 hours To the Funeral completely filled		ysician: To the best of my niner:On the basis of exar and manner stated.								
F S S	29b. Manature and title of certifie				nse number C.M.E.		29d. Date signed (N			
	30: Name and address of person Laron Locke MD. As	who completed cause of desistant Medical Exa		V. Baltimore Str	eet, Baltimore	e, MD 21223	•			
State Registrar				parker						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. In the Per Phy G934 12/14/2012 JH State of Maryland / Department of Health and Mental Hygiene 20 | 2 40605 For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ○○ Andy Hom-Loon Shu Physician/ DEC Day Year 1649 2017 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HOWARD GENERAL HOSPITAL Howard OLUMBIA COUNTY 7. Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Ye Birthplace (State or Foreign Country) Funeral Min Hours 1 M 2 □ F 579-92-2583 66 Director APR.07, LEGUE, CHINA Usual Residence of Decedent or 28a-f show 10a. State and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** MD Howard Columbia 1 🗆 Yes 2 🏝 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7162 Harp String 21045 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 X Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Asian 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bank Note Engraver Dept of Treasury Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ UNK UNK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Esther C. Shu (Wife) 7162 Harp String Columbia, MD 21045 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Departion 5 ☐ Other (Specify) cemetery, crematory or other place) Atlantic Crematory 12/13/2012 Glen Burnie, MD 21. Signature of Funeral Service Licenses Name and Address of Facility ary L. Kaufman Funeral Home at MMP, Inc 250 Washington Blvd Elkridge, MD 21075 23a. Part 1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or treat failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner HOUR MYOLARDIAL Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2. No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 1 Tes 2 No 1 ☐ Inpatient 2 ► ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending ות 24 hours מונה עבר. he Funeral Director: Aft וראים filled in by the fu 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2 To the F 29b. Signature and title of certifie DOO 73898 DEC. 10, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) tose11720+ GENERAL FEWALD COUNTY 31. Date filed (Month, Day, Year)

DEC 1 4 2012 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 40606 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month SUSAN CAROL STEARNS Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GOOD SAMARITAN HOSPITAL BALTIMORE CITY BALTIMORE CITY Funeral Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) 213-84-8397 Director 1 □ M 2**XX**F Jan. 2, 1950 MD. 62 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Marvland Baltimore City Baltimore City 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2100 Westfield Avenue 21214 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes X2/X No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married XX Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 vrs N/A Head Cashier Bi Rite Supermarket 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kenneth W. Addicks Doris Vivien Cover 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2100 Westfield Avenue Baltimore, Md. 21214 Robert D. Stearns (Husband) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory, Inc. 20c. Location - City or Town, State 1 ☐ Burial XX Cremation 3 ☐ Removal from State 12-8-2012 Baltimore, Md. 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Lassahn Funeral Home eshord 7401 Belair Rd. Baltimore, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Concer with day Due to (or as a consequence of) Medical Examiner Sequentially list conditions, Examine It any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of: Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death ate has been signed by the page 2 should be detached g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Congestive heart failure, chronic obstructive pulmonary disorder, 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an alcoholism, anxiety, depression After this certificate has autopsy performed? Yes 2 No 24 hours after death.
• Funeral Director: After this certifica etely filled in by the funeral director, I 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical within 24 hour To the Funer completely file 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES - 000 December 7th, 2012 sa 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Blvd. Baltimore, MD 21239 Loch 5601 Raven 31. Date filed (Month, Day, Year)
DEC 1 4 2012

DHMH 17 Rev 06-2011

State Registrar

Starns

Susan

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 12 Physician/ 2012 8:58 AM M Carlyn Janet Spooner Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAltimore Towson Gilchrist Center If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral (Month, Day, Year) Davs Min. Months Hours Director 015-28-0167 1 M 2 X F 06/27/1930 Massachusetts 82 Usual Residence of Decedent or 28a-f show 10b. County 10c. City. Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 No Baltimore Baltimore 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral U.S.A 21237 8411 Coco Road within 72 hours after death . Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 🕅 Married δ Maryland 21215-0036 1 ☐ Yes 2 X No Specify If Yes Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 7 and Mental Hygiene. 7 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12 Registered Nurse Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Edna Upham 1 and 2 should be of Health and Meritem 27 is mark <u>Albert Rav Brvant</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8411 Coco Road - Baltimore, Maryland Richard M. Spooner (husband) injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/15/2012 Baltimore, Maryland Zion Luth.Ch. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lassahn Funeral Home, Inc. 7401 Belair Road - Baltimore, Maryland 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) [']Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or se a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and -trans Due to (or as a consequence of): ate has been signed by the attending physician a page 2 should be detached for use as the burial-Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2. autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\subseteq \text{Nursing Home} \) 5 \(\subseteq \text{Residence} \) 6 \(\text{N Other (Specify)} \) 1 🗌 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 IDOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only/one) 3 ature and title of certifier 29b. Sign 29d. Date signed (Month, Day, Year) License number

DHMH 17 Rev 06-2011

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra s Signature

31. Date filed Wonth, Day Year)
DEC 1 4 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40608 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 23:00 M abatin 1012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore University of Maryland Medical Center If Under 1 Year If Under 24 Hrs 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 167-30-1862 Hours Director 73 **XX**M 2 □ F 2/28/39 PA Usual Residence of Decedent of Health end Mentel Hygiene. i item 27 is marked other than "natural", or Itema 23e or 28a-f show other treumetic event, the Medical Examinar must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours efter death with the Maryland Director MD Prince Georges Laurel 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 356 Dameron South 20724 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. White Armed Forces?

Y⊠ Yes 2 □ No 1 Never Married 2 Married ۾ Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Mail Postal Service 0 Carrier Be permit. Page 1 and 2 should be filed Department of Health end Mentel Hy Important: If item 27 is marked oth any liviny or other treumetic event ones. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Americo Sabatini Stavetski ဂ္ Josephine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **Barbara** Sabatini / Wife 356 Dameron South, Laurel MD 20724 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State St. Mary's Cemetery 1 Burial 2 Cremation 3 Removal from State 12/15/12 Mocanagua, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Victor P. Doda 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Ave, Baltimore MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Shock Priysicia i Medical resulting in death) Due to (or as a consequence of): Examiner month - Organ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examine Due to lor as a consequence of: ete has been signed by the attending physician end pege 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificete be executed Stage Alcoholic Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Month g 🗌 Unknown g 🗌 Unknown Part II<mark>. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? After this certificate 1 ☐ Yes 2 ☐ No 1 Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred To the Hospital or Attending within 24 hours efter death.

To the Funeral Director: Afte completely filled in by the fune. 1 Matural 5 Pending 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 1. Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar South

32. Registrar's Signature

Greene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 40609 Reg. No [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year 2012 Marc David Silberski 9:30 ΔΜ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Shady Grove Adventist Hospital Rockville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** 8 Date of Birth Days Hours Min (Month, Day, Year) 226-86-0576 Director 1 XM 2 🗆 F 54 5-19-1958 New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director the Merical Examiner must be notified 28a-f MO Germantown Montgomery 1 X Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Items 23a Funeral United States 20874 19617 Galway Bay Circle #303 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. nd Mental Hygiene. marked other than "natural", or δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Never Worked Never Worked Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be Edith Krenkel Robert Silberski it of Health and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 511 Calvin Lane, Rockville, Maryland 20851 Marlo Silberski - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or of once, Page 1 1 K Burial 2 Cremation 3 Removal from State Chessed Shel Emes 12-12-2012 Capital Heights, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Edward Sagel 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapel 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Cardio disease or condition resulting in death) Due to (or as a consequence of): Medical Examiner neumon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and I for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Encephalo-pall that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Pregnant at time of death signed by the a Id be detached f 1 ☐ Yes ∠∟ 9 ☐ Unknown 9 | Unknown P.O. I Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Circhosis Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? renal 24a. Was an has autopsy performed this certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death,

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: ည 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier engalle 7/323 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Ctr Dr Rockville MD 20850 9901 Ushakiran Yenia alla mD 31. Date filed (Month, Day, Year) State DEC 1 4 2012 Registrar

DHMH 17 Rev 06-2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10^{Day}2012 Agnes Faye Samuels 12:05 AM Dec. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 429 Margaret Avenue Baltimore Essex 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Birthpic... Country)MD 213-26-3315 Jan. 9, T929 Director 1 M 2 X F 83 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked outler than "naturel", or items 23a or 28e-f show emportant: If Item 27 is marked outler than "naturel", or items 23a or 28e-f show emportant: In Item 25 is marked outler than "naturel", or items 23a or 28e-f show emportant: If Item 25 is marked outler than "naturel", or items 23a or 28e-f show emportant in Items 25a or 28e-f show emp 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Essex 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 429 MArgaret Avenue 21221 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. Š 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: Completed 3X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4 or 5+) Homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Otmer Ford Ersel Callahan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
429 Margaret Avenue Baltimore MD 21221 Bruce Samuels /son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place)
Gardens of Faith 12/15/12 Baltimore MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility 300 Mace Ave. Balto. Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any seeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physiclan/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes No
9 Unknown ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed Yes 2 or Attending Physician: The 2 🗌 No 1 Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No ဂ္ဂ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation
6
Could not be filled in by the 3 Suicide 4 Homicide To the Hospitel or Att within 24 hours after do To the Funerel Direct completely filled in by 1 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier ath (Item 23a) (Type, Print) Name and address of person who completed cause of d

Registrar

31. Date filed (Month, Day, Year)

Asalle

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2

			1 - State Registrar		C	ertificate of	Death	Reg.	No. UIZ	40011
			1. Decedent's Name (First, Middle, La.	st)			2	2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medi		ELIZABETH C. ST	ORCK				ecember		2 755 PM
	Examir		4a. Facility Name (If not institution, giv	1 4		4b. City, Town, o	Location of Death	1	4c. County of Deat	th .
				VERSIDE		DE,	LCAMF		MARFO	RD
	Funeral		5. Social Security Number 6. S	- AT	s. <i>last birthda</i> Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min.	B. Date of Birth (Month, Day, Ye	ar) 9. Bir	thplace (State or Foreign ountry)
	Director		216-20-0957 Usual Residence of Decedent	LM 2MF 88	115.		3	3/3/1924	MAR	YLAND
	and bw		10a. State 10b. County	10c. 0	City, Town or	Location				10d. Inside City Limits
	f sho	ō	MD BALTIMO	DE	DAD	KVILLE				1 □Yes 2 No
	the 28a notif	rec	10e. Street and Number		I M	10f. Zip Code		10g.	Citizen of What Co	ountry?
	3a ol		8303 KENDALE ROA	D		21234	4		USA	
	72 hours after death with the Maryland natural", or items 23a or 28a-f show after Examiner must be notified at	Completed by Funeral Director	11. Marital Status	12 Was Decedent Ever in	U.S. 13	B. Was Decedent of H	lispanic Origin? (Speci an, Mexican, Puerto Ri	ify Yes or No-	14. Race - Ame	
9	after or ite mine	显	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		1 ☐ Yes 2 ☐XNo	an, mexican, Puerto Ri Specify:	can, etc.)	Black, White	e, etc.
93	ours iral",	d b	3	Year or Dates:		To les 20200	эреспу.		Specify: W	HITE
21215-0036	72 h 'natu	ete	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. Dec	cedent's Usual Occup we kind of work done	eation during most of working d)	16b	, Kind of Business/	Industry
121	/ithin ne. han '	臣	Elementary/Secondary (0-12)	College (1-4or 5+)			d) -		OLDI HON	TD.
	fed w Hygie her t nt, in		12TH GRADE 17. Father's Name (First, Middle, Last)		HC	MEMAKER	18. Mother's Name (First Middle Mair	OWN HOM	巴
ă,	be fi	Be	JOSEPH MEYD	'			ELIZABETE		•	
Ĕ	nould d Me mark mark	ဍ		Time Drietl	105 14-	ilia - Addans (Cinesi	and Number or Rural			Zin Cadal
Maryland	d 2 sh than 7 isr traur		19a. Informant's Name/Relationship (JEAN-MARIE STORCK				COURT APT		ST HILL,	·
ئو لا	1 an Heal em 2		20a. Method of Disposition			position (Name of	Dat Dat		Location - City or	
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Marical Examiner must be notified at once.		1 Burial 2 Cremation 3 □	Removal from State MO	STEHOL	Y"REDEEME	12/15	/2012 B	ALTIMORE,	MD
Ē	artme		4 ☐ Donation 5 ☐ Other (Specification 21. Signature of Funeral Services Licer			TERY Name and Addre				ERAL HOME, P.
Ba	permi Depa Impo any ir	l li		1100217			RAVEN BLVI			286
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o,	e exe ian al irial-t	Ë	resulting in death) Last	Due to (or as a conse						
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39 x	ertific ing p e as t	Med	IF FEMALE:							
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0	the a	Physician	1 □ Yes 2 No 9 □ Unknown	4 ☐ Pregnant at time o 9 ☐ Unknown	death (5 ☐ Other (specify) _				
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Rec	ne lav has ge 2 :	ш						autopsy performed	prior to	completion of cause of
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Ξ	sicla s cert irectc	Be (examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 [T EB/Outpat	iont 3 🗆 DOA Oth	er: 4 Navening Hame		e 6 ☐ Other (Spe	- 14 -)
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on	th. : Afte	ţi	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	Injury		k? Yes 2 □No			
Vis	I or Attendi after death. Director: A	ij	3 ☐ Suicide 6 ☐ Could not be determined	e 28e. Place of Injury - At building, etc. (Spec	home, farm,	street, factory, office	28	f. Location (Stree	t and Number or R	ural Route Number,
Ö	al or s afte al Dir	Certification: To	4 ☐ nothicide	building, etc. (Spec	Aly)		Į.	City or Town, S	iale)	
	ospit hour unera			nysician: To the best of my kinner: On the basis of exami						
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit	Medical	one)	and manner stated.	lation and/or					
	Voit To 1	Σ	29b, Signature and title of certifier	\bigcap		29c. Licens	e number	29d.	Date signed (Mont	th, Day, Year)
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	3 M		30. Name and address of person who	complet d cause of death (Ite	em 23a) (Typ	e, Print)	03-11	n A - A	1 Δ	200 2 10111
	O,		31. Date filed (Month, Day, Year)	32: Registrar's Sign	bature 6	11 /11	CPN-11/	10/, /10	1711.1	MD-01014
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Division of Vita To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, I		29a. Certifier 1	Certifying Physician Medical Examiner:	n: To the best of my	/ knowledge, dea mination and/or i	th occurred at the to	time, date and place opinion, death occu	e, and due to the	cause(s) and man date and place, an	ner as stated. d due to the cause(s)
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To t	Σ	29b. Signature and tit	le of certifier	~	MAD	29c. Licen		205	29d. Date signed (2 10
100		POR	20		1011	1,70	10100	Altha	12	de Ro
UM		30. Name and address	s of le son who complet	ted cause of death	(Item 23a) (Type	Print) DE	204	Ball	timer	ds Rel c MD-212

State Registrar

31. Date filed (Month, Day, Year)

10,2012 Dec. Salisbury /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Genesis Franklinwoods Baltimore 8. Date of Birth (Month, Day, Year)
Dec. 23,1914 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 □ F Months Days Hours 97 217-12-0924 Director Usual Residence of Decedent with the Maryland 10c, City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at MD Baltimore Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1400 Homestead St. 21218 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 72 hours after 1 □ Yes 2 □ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. ģ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired)

Self Employed Master Elementary/Secondary (0-12) College (1-4or 5+) Cosmetology 12th Beautičian is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Moses Redd Lula Scott ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrea Richardson (Grandchild) permit. Pages 1 and 2.
Department of Health a Important: If item 27 is any injury or other tratonce. 1400 Homestead St. Balto, Md. 21218 20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore Cem
Bayview Crematory

Date

20c. Location - City or Town,
14

Dec. 13, 2012 Balto, Md. 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Grema 3 Removal from State 5 ☐ Other (Specify) 4 □ Donation 22. Name and Address of Facility Calvin B. Scruggs Funeral Home 21. Signature of Funeral Service Licensee 1412 E. Preston St. Balto, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Herin **Physician** ACCINOMA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events) Due to (or as a consequence of) Examiner the death certificate be executed the burial-trar and resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical use as attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 18 months? 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown are rras been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24a, Was an autopsy 2.0 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 No Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred ne Hospital or Attending P 124 hours after death. Ne Funeral Director: After t 1 Natural 2 ☐ Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. within 2. 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4NUNESCA

DEC 1 4 2012

31. Date filed (Month, Day, Year)

DM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 20a-b, per fh, g934 12-14-12 sm State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 201

6: p ^M

9. Birthplace (State or Foreign Country) VA

Black, White, etc.

Month

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

Day

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

1 Yes 2 □ No

2. Date of Death

Month

DHMH 17 Rev 1/2001

State

Registrar

1 - For State Registrar

Physician

1. Decedent's Name (First, Middle, Last)

Rose

Α.

D13462

MD 2305 Windwept Ct. Fallston, MD 21047

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Frances Jane Tate 2012 4:00 P M December Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Howard 9080 Moonshine Hollow Unit M Laure1 Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** (Month, Day, Days Hours Maryland Director 230-38-4297 Aug. shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland must be notified at Funeral Director 28a-f 1 Yes 2 X No Laure1 Maryland Howard 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a USA 9080 Moonshine Hollow Unit M 20723 "natural", or items dical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. Page 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene. lant: If item 27 is marked other than "natural", or ury or other traumatic event, the Medical Examir Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Specify: 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) School Bus Driver Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Fannie Handy James M. Gore 19a. Informant's Name/Relationship (Type, Print)

Kathy M. Smallwood - Daughter 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) 8060 Leishear Road, Laurel, Maryland 20723 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Atlantic Crematory 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 12/13/2012 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Gary L. Kaufman F.H. @ MMP 21. Signature of F Ineral Service Idenses 22. Name and Address of Facility 7250 Washington Blvd., Elkridge, Maryland 21075 M01283 23a. Part 1. Enter the disease, shock, or heart failure. Lis complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, bly one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Schemic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate

Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed and-trans that initiated events Due to (or as a consequence of) resulting in death) Last ed by the attending physician a detached for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death No 1 Inknown 9 Unknown cate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy this certificate Yes 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🔀 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural Accident (Month, Day, Year) 5 Pending 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier (M) 30. Name and address of person wh 8 0 32. Registrar's signatur 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #21, per fh, g934 12-14-12 sm
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEMBER Medical 4a. Facility Name (if not institution, give stre Examiner 4c. County of Death Baltimore Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Director 1 □ M 2 🔀 F 30 7/24/36 Pennsylvania th and Mental Hygiene. 27 is marked other then "natural", or items 23a or 28e-f show treumatic event, the Medical Examiner must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Hallam 1 X Yes 2 No Pa. York 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 17406 USA 416 A. <u>Buttonwood Lane</u> 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. If Yes. Give Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Electrical Generator Exec. Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 end 2 should be fi of Health and Mental ltem 27 is marked ၉ Mildred Hoover Lewis B. Zimmerman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 416 A. Buttonwood Lane, HALLAM, Pa. 17406 Department of Health Important: If item 27 any Injury or other tr Wayne R. Troutman Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🕅 Cremation 3 📉 Removal from State 4 Donation 5 Other (Specify) 12/16/12 Evans Cremation Co. Leola, Pa. 21. Signature of Funeral Service Licensee

Jonathan D. Hibner 22. Name and Address of Facility 260 E. Main St. Matinchek & Daughter Funeral Home, Middletown, Pa 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Rapid Ventrevlar Responce Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury sician and Exami that initiated events Due to (or as a consequer resulting in death) Last physician Physician/Medical as the t IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day page 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physician: The I within 24 hours after death.
To the Funeral Director. After this certificate h completely filled in by the funeral director, page performed' 2 🗌 No 1 Tyes 25. Was case referred to medical æ 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) <u>م</u>| 1 Tes 1

Inpatient 2

ER/Outpatient 3

DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 Tes 2 🗌 No Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie who completed cause of death (Item 23a) (Type, Print) e and address of person amin 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 4 Registrar

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 40617 Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DÉCÉMBER 12, 2012 10:01am JOHN HENRY THOMAS JR. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death JOSEPH RITCHIE HOSPICE CENTER N/A BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 8. Date of Birth Days Hours Min (Month, Day, Year) **Director** 218-80-6856 50 1 X M 2 □ F 11-28-1962 MARYLAND Usual Residence of Decedent or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 X Yes 2 No BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 718 CLIFFEDGE RD. 21208 12. Was Decedent Ever in U.S. Armed Forces? 1 ⚠ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: BLACK Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) -12--0-FIREFIGHTER BALTIMORE CITY t. Page 1 and 2 should be filed wittent of Health and Mental Hygiertant: If item 27 is marked other ijury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOHN H. THOMAS SR. CATHERINE HICKS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4621 PANACEA RD. PIKESVILLE, MARYLAND 21208 JACQUELINE THOMAS(WIFE) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ⊓ Cre 1 XBurial ation 3 Removal from State permit. Page Department of Important: If any injury or once, GARRISON FOREST VETERANS 12-27-2012 OWINGS MILLS, MD. 4 Donati n 5 (Specify) JONATHAN HIBNER 2. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signaturu 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part / Enter the disease, or complications that cause shock, or heart failure. List only one cause or each limmediate Cause (Final Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi as the burial-transit that initiated events Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Pregnant at time of death 23e. Did tobacco use con bute to the cause of death? 3 Probably 4 ☐ Unknown 1 Yes 2 LNo . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform Nes 2 □ No Be 26. Place of Death (Check only one) P Other: 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: er of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🗌 No Investigation Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date sign od (Month, Day, Year)

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				Department of Health and M Certificate of Death	lental Hygiene Reg. No. 2012	40618					
ı	Physicia Medic		1. Decedent's Name (First, Middle, Last) Uanita L Thomas		2. Date of Death Month 2 Day 2 Year	3. Time of Death					
22.22	Examir		4a. Facility Name (if not institution, give street and number) 127 W. Ostend Street	4b. City, Town, or Location of Death Baltimore	4c. County of Dea	th N/A					
	Funeral Director		5. Social Security Number 233-70-9655 Sex 1 M 2 M 7. Age (In yrs. last birth 83 Y 1 1 1 1 1 1 1 1 1	day) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		thplace (State or Foreign buntry) WV					
	laryland 3a-f show ified at	Director		or Location Baltimore		10d. Inside City Limits 1 🗶 Yes 2 □ No					
	with the N 23a or 28 1st be not	Funeral Dir	10e. Street and Number 127 W. Ostend Street	10f. Zip Code 21230	10g. Citizen of What Co						
9800	ge 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	1 Never Married 2 Married 1 Yes 2 No	13. Was Decedent of Hispanic Origin? (Spellif Yes, specify Cuban, Mexican, Puerto I	Rican, etc.) Black, Whit						
Baltimore, Maryland 21215-0036	d within 72 hor ygiene. her than "nat it, the Medica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12	Decedent's Usual Occupation Give kind of work done during most of workir life. DO NOT use retired) Homemaker		Industry Home					
yland	should be filed n and Mental Hy, r is marked oth raumatic event	17. Father's Name (First, Middle, Last) P Issac Holstein 18. Mother's Name (First, Middle, Maiden Surmame Edith Hagar									
, Mar	nd 2 shou ealth and m 27 is m	Route Number, City or Town, State, Zi Baltimore MD 212	o Code) 30								
imore	permit. Page 1 and 2 si Department of Health a Important; If item 27 is any injury or other tra		1 X Burial 2 Cremation 3 Removal from State cemetery,	, crematory or other place)	ate 20c. Location - City or 7/2012 BAltimo						
Balt	permit. Depart Import any inj		21. Spring I Francisco Victor P. Doda	Charles L. Stevens 1501 E. Fort Ave, E	Funeral Home, Inc altimore MD 21230	•					
	Trynician/ Medical	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	ot enter the mode of dying, such as cardiac of	respiratory arrest,	Approximate Interval Between Onset and Death					
	Examiner	Jer.	Sequentially list conditions, if any, leading to immediate	Use		until death					
	ate be executed physician and the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last c):							
8760	ificate be ig physicia as the bur		d								
). Box 687	the Hospital or Attending Physician: The law requires that the death certificate be executed that 4 hours after death. The Funeral Director, the this certificate has been signed by the attending physician and the Funeral Director, page 2 should be detached for use as the burial-transitied filled in by the funeral director, page 2 should be detached for use as the burial-transities.	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of de Month	livery Day Year					
ls, P.O.	uires that i n signed t		Part II. Other significant conditions contributing to death but not resulting in Chronic Obstructive Lung.	the underlying cause given in Part I.	23e. Did tobacco use contribute to	the cause of death?					
Division of Vital Records,	rsician: The law require s certificate has been si lirector, page 2 should I	Completed by	3		autopsy prior to performed? death?	topsy findings available completion of cause of					
Vital	Physician: The lav r this certificate has aral director, page 2	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outp		only one) ne 5 X Residence 6 □ Other (Spec	ify)					
ion o	tending F death. tor: After the funer	28a. Date of injury 1									
DIVIS	pital or Ai burs after eral Direc filled in by		4 ☐ Homicide determined 286. Place of Injury - At nome, farm building, etc. (Specify)		8f. Location (Street and Number or Rui City or Town, State)						
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director, After this, completed filled in by the funeral dir	Medical	29a. Certifier (Check only one) 1 ■ Certifying Physician: To the best of my knowledge, de conly one) 1 ■ Certifying Physician: To the best of my knowledge, de conly one) 29b. Signature and title of certifier	investigation, in my opinion, death occurred at t	he time, date and place, and due to the o	cause(s) and manner stated, stated.					
	H M		Mula Brown A.D.	D002599		2012					
			31. Date filed (Month, Day, Year) , 32 Registrar's Signature	iman Park Dri	e Baltimore,	MD 21211					
	Stat Registra		DEC 1 4 2012 June & Jak								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ ρМ Celia White Tabor 2012 12 3:30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 4 North Court Bet.besda Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, Year) 031-30-3036 1 □ M 2 🛛 F Director Yrs Massachusetts 11-15-1918 ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified at</u> within 72 hours after death with the Maryland 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Bethesda Montgomery 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20B14 4 North Court United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government 5+ Medical Doctor permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other t any injury or other trainmosts. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Mina Raffelofsky Samuel H. White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Tabor - Son 5110 Cape Cod Court, Bethesda, Maryland 20816 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beth El Congregation Cem. 12-9-2012 Boston, MA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Oanzansky-Goldberg Memorial Chapel Brad Smetzer 1170 Rockville Pike, Rockville, Maryland 20852 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Acute Cardiopulmonary Arrest disease or condition Medical resulting in death) Due to (or as a consequence of) Éxaminer Cerebral Vascular Accident Days Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to for as a consultence of Exami or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Severe Vascular Oementia 1 Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has page 2 1 ☐ Yes 2 ☐ No eral Director: After this certific filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 1 🗌 Yes 2 XN0 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 2 Accident 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral Completely filled Medical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Purse Prochitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Prochitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Prochitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b 29d. Date signed (Month, Day, Year) 12-10-2012 MD11924 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month Day, Year)

Steven Lerner, MD - 5530 Wisconsin Avenue, #800, Chevy Chase, Maryland 20815

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ BAM OSON December Medical 4a. Facility Name (if not institution, give st reet and number 4b. City, Town, or Location of Death Examiner 4c. County of Death TOWSON
If Under 1 Year If Under 24 Hrs. tospice 151 MOZE 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours Director 1 M 2 D F 6 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any Injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 ☐ No to more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21206 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ MONLOSOY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mompson Baltimore, 20a. Method/of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or 1 Neurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) timore 21. Signature Funeral Service Light ee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final metastronic Carcinoin Physician/ ease or condition WEUZ) Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami as the burlal-transit The law requires that the deeth certificate be executed Due to (or as a consequence of): resulting in death) Last ate hes been signed by the attending physician page 2 should be deteched for use as the burla Physiclan/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate hes autopsy performed' 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 000 Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA MUKA LLO 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Division 1 Yes 2 No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 2012 December s of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre works 702 SU HARON 31. Date filed (Month, Day, Year) 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 3: 17 pm Broderick M. Turpin 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Union Memorial Hospital Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) OV. 3, 1943 Days Hours 216-36-3895 69 Director 1 M 2 F Nov. Yrs. VA item 27 is marked other than "neturel", or items 23a or 28a-f show other traumatic event, the Madical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits within 72 hours after deeth with the Maryland 1 Yes 2 No Baltimore Essex Ճ 10e. Street and Number 10g. Citizen of What Country? USA 10f. Zip Code Funera 21221 1737 Eastern Blvd Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married 3 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) filed within 72 tal Hyglene. Elementary/Secondary (0-12) College (1-4 or 5+) <u>disab</u>led 10±h Be permit. Page 1 and 2 should be flied Department of Health end Mental Hy important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mamie Clark Jess Turpin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1737 Eastern Blvd. Essex, MD 21221 19a. Informant's Name/Relationship (Type, Print) Agnes Turpin (wife) 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of or other place 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Cemetery 12/15/12 Middle River, 4 Donation 5 D Other (Specify) 21. Signature of Fundal Service Licens 22. Name and Address of Facility 300 Mace Ave. Essex, Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MYOCALDIAL INFARCTION disease or condition Day S Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 124 hours efter death.

Funeral Director: After this certificate has hear airmed hear and a feet of the certificate has hear airmed hear and a feet of the certificate has hear airmed hear and a feet of the certificate has hear airmed hear and a feet of the certificate has hear airmed hear and a feet of the certificate has hear airmed hear and a feet of the certificate has hear airmed hear and a feet of the certificate has hear airmed hear and a feet of the certificate has hear airmed hear and a feet of the certificate hear and a feet of the certificate hear airmed hear and a feet of the certificate hear airmed hear and a feet of the certificate hear airmed hear airmed hear and a feet of the certificate hear airmed hear and a feet of the certificate hear airmed hear and a feet of the certificate hear airmed ate has been signed by the attending physicien end pege 2 should be deteched for use as the buriai-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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1 Yes 2 No
9 Unknown Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 Nio 1 🔲 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an burs efter death. eral Director: After this certificate has t filled in by the funeral director, pege 2 s autopsy perform 1 ☐ Yes 2 ☐ No å 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) |၉ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical To the Hospi within 24 hou To the Funer completery fil 29a, Certifier 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) AT2438946 12 10 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SERAFI UNION Memocine Hospi TAL. 201 E. WATVESSHY Ave, Baltimore MO M.D 32. Registrar's Signature State arks Registrar

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	Examin		4a. Facility Name <i>(if not institution,</i> 8820 Walther Bl	-	416 Baltimore			of Death	4c. County of Death Baltimore						
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	the Ma or 28a e notif	E E	10e. Street and Number	TIMOLE		рать	imore 10f. Zip C	ode		·		10g. Ci	tizen of What	Country	
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7 500	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fu	11. Marital Status 1 ☐ Never Married 2 🏝 Marr 3 ☐ Widowed 4 ☐ Divorced	ied 12. Was Decedent I Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	If Yes, specify Cuban, Mexican, Puerto F No 1 ☐ Yes 2 ☐ No Specify:					ecify Yes or No- Pilican, etc.) 14. Race - Am- Black, Whi Specify: WI			/hite, etc		
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DC Baltimore,	Page 1 and of Hambert		20a. Method of Disposition 1 ☐ Burial 2 🎦 Cremation 4 ☐ Donation 5 ☐ Other (S	3 ☐ Removal from State	Hi	ace of Dispo emetery, crer .11top	natory or oth Servic	er plac Ce (e) Corp	12/1			ocation - City VSON, I		i, State
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_	٤/		30. Name and address of person Renald Te 11 31. Date filed (Month. Day, Year)	revs, DO 88	200 V	Val-ther	- Boul	e Va	N,	Park	ville.	Ma	Mene	ZI	234
	Sta Registra		31. Date filed (Month, Day, Year)	2012 22. Registr	ar's Sign	ure pa	par !							-	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Ma	aryland / Dep <i>Ce</i>	artment of F rtificate of L			ene 201	2 40623		
	Physicia	ıň/	Decedent's Name (First, Middle, Last) William Trussell				2. Date of Death December		3. Time of Death 5:12 Р м		
1	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Death	December	4c. County of De	eath		
wy.	Formul		3 Green Peak Court 5. Social Security Number 6. Sex 7. Age	e (In yrs. last birthday)	Phoenix If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Baltimo	Birthplace (State or Foreign		
	Funeral Director		217-26-0727 1X M 2 🗆 F	82 Yrs.	Months Days	Hours Min.	(Month, Day, Ye	ear) (r) Country) 1930 Maryland		
	show	 -	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation		Берг. 20	7 1730 118	10d. Inside City Limits		
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Maryland 21215-0036	permit. Fage 1 and 2 should be filed within 72 hours after death with the Maryland brackment of Health and Mental Hygiene. Important: If time IZ is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	17. Father's Name (First, Middle, Last) Edward Trussell			18. Mother's Name	e (First, Middle, Mai	den Surname)			
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Balt	Depart Depart Import any inj		21. Signature of Fundamental Vice In the	22	2. Name and Addres	road, To	k Towson wson, Mar	Funeral 2	Home, Inc. 21204		
ī			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause in each line.	the death. Do not ent	er the mode of dying	g, such as cardiac o	r respiratory arrest,		Approximate Interval Between		
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To Local	ansit	Examiner	cause. Enter Underlying Cause (Disease or injury	consequence of):							
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3760	g phys	Nedic	d								
Box 687	attending p	ian/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of the past 12 months?	2 🗌 Fetal death 3	Ectopic pregnanc	у		23d. Date of o	delivery Day Year		
). B C	igned by the a	Physician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at 9 ☐ Unknown	time of death 5 L	Other (specify)			Month	Day real		
s, P.O.	signed t	by	Part II. Other significant conditions contributing to death but	it not resulting in the u	ınderlying cause giv	en in Part 1.			to the cause of death? Probably 4 🗆 Unknown		
Records,	s been sign	Completed					24a. Was an	24b. Were a	autopsy findings available		
Rec	cate has	Com					autopsy performe 1 \(\sum \) Yes 2	d? death'	o completion of cause of ? /es 2 \(\text{No} \)		
/ital	r this certificate	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▶ No Hospital:	nt 2 ER/Outpatier	Othe	ace of Death (Check					
Division of Vital	h. After this funeral c		27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day,	y 28b. Time of		rat 2	me 5 X Residence 28d. Describe how i		acify)		
Sion	after death. Direct or: Ai d in by the fu	27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 4 Homicide determined 28a. Date of injury 28b. Time of injury work? 1 Natural 5 Pending Investigation 3 Suicide 4 Homicide determined 28b. Time of injury 1 Sucriment of Death 1 Natural 5 Pending Investigation 3 Suicide 4 Homicide determined 28c. Injury at work? 1 Yes 2 No 28d. Describe how injury occurred									
Divi	eral Dire		4 Homicide determined 28e, Place of Injur building, etc.	(Specify)			City or Town, S		iura rioute Number,		
Hosn	Fun Fun etely	Medical	29a. Certifier (Check only one) 1 Secretifying Physician: To the best of more than the basis of expension of the basis of	amination and/or invest	tigation, in my opinio	n, death occurred at	the time, date and p	place, and due to the	e cause(s) and manner stated.		
To_	vithi Con	_	29b. Signature and title of certifier	2/20	29c. License		29d	. Date signed (Mor	1		
			30. Name and address of person who completed cause of de	ath (Item 23a) (Type. I		0649		2/12/	12012		
			John W. Bowie, MD 1734 Yo	rk Road, I	uthervil.	le, Maryl	and 2109)3			
	Stat Registra	e ar	31. Date flood (Alonth, Pay Year)	's Signatur							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 20 12 40624 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month awrence Voge Decemb 12:28 PM Medical 2017 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Baltimore Cente, Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign Country) MD 213-86-1029 Months Days Min, 39 Hours Director 1**X** M 2 □ F or than "natural", or items 23a or 28a-f show the Wedical Expriner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 237 1/2 S. Stricker St. 21223 USA 12. Was Decedent Ever in U.S. Armed Forces 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 ☐ Married Black White etc Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Discibled Dischled permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe eny Injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lawrence Joseph Vogel Daisy Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 237 1/2 S. Stricker St., Baltimore, MD 21223 Wendell Shore / Uncle Mathod of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Mt. ZION Cemetery or other place) 12/17/2012 Baltimore, MD . Signature of Funeral Service Licensee Ralley Funeral Home and Cremation Service, 4023 Annapolis Rd., Halethorpe, MD 21227 PA M01452 2. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Priysiciani Endocarditis disease or condition Medical resulting in death) Due to (or as a consequence of): Éxaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events Examine Due to (or as a consequence of): attending physician and I for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day Year After this certificate has been signed by the a funeral director, page 2 should be detached it 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 24 hours after death. • Funeral Director: After this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending the Investigation Suicide
Homicide within 24 hours after des To the Funeral Directon completely filled in by th 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge death occurred at the time, date and place and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 60914179 2012 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21201 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 2 per doc 5 per fh 9934 12-14-12 yt. State of Maryland / Department of Health and Mental Hygiene 20 1 - For State Registrar 40625 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 11-22-12 Physician/ Month 11:42 A M Marion C. Vane Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 3633 Clarenell Road Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Social Security Number 6 Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral Days Hours Min. Dec. 13, 1923 1 🛛 🗶 1 2 🗆 F Maryland **Director** 88 Yrs 218-16-1659 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at rector Baltimore City Maryland 1 √2 Yes 2 □ No ā 10e. Street and Number ō 10f. Zip Code 10g, Citizen of What Country? must be items 23a Funeral 21229 3633 Clarenell Road United States 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces? Black, White, etc. ö 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Trucking 12th N/A Platform Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mentall Important: If item 27 is marked o any injury or other traumatic eve မ Levin Vane Ella Hoyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3633 Clarenell Road, Voiletville, Maryland 21229 Geraldine Vane / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗀 Removal from State Loudon Park Cemetery Nov. 27, 2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Euperal Service Licensee 22. Name and Address of Facility AMBROSE FUNERAL HOME, INC. NO144 328 Sulphur Spring Rd., Arbutus, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician TROK disease or condition Medical resulting in death) Examiner YA L Sequentially list conditions, Examine If any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to for as a consequence of that the death certificate be executed burial-transit and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Pregnant at time of death signed by the a Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law has autopsy performed death? certificate 2 - No Yes 2 L+N within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3 ATTEN BING 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) POSNER MARC M.0 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Gloria Beatty Walker 2:30 A December Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Harford Examiner 4b. City, Town, or Location of Death Harford Memorial Hospital Havre de Grace Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Davs 128-54-5502 North Carolina Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director r 28a-f sl notified Marvland Harford Aberdeen 1 X Yes 2 ☐ No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be Funeral 204 Woodland Green Way 21001 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2 XNo Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Health and Mental Hygiene. Iem 27 is marked other tha Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Verna Beatty Page 1 and 2 should be Maryl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yvonne Phillips 204 Woodland Green Way Aberdeen, Maryland 21001 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury or Hawes Chapel Cemetery 12/08/12 Atkinson, NorthCarolina 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 21. Signature of Funeral Service Licensee 6009 Harford Road Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Phy irian disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and I for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Completed by Physician/Medical The law requires that the death certificate be 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death g Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 Ho 24a Was an has performed After this certificate Vital Hospital or Attending Physician: Be (completed filled in by the funeral director, 26. Place of Death (Check only one) examiner? Hospital Other: Certificate: To 1 🗌 Yes 2 🗆 N ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manne eath 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury Natural 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: At 2 Accident
3 Suicide
4 Homicide 2 No 1 Yes Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 🖵 Certifying Physicîan: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) death (Item 23a) (Type, Print) 30. Name and address of person who comp State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 11, 2012 Adin Weiser December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c._County of Death Laurel Regional Hospital Prince George's aurei Birthplace (State or Foreign Country) Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Davs Hours Director 099-18-1124 1 🗆 M 2 🗶 F 88 Feb. 6, 1924 New York Usual Residence of Decedent shov 10a. State 10b. County should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits ms 23a or 28a-f s must be notified MD 1 ☐ Yes 2 X No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1400 East West Hwy. 20910 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ıral", or iten I Examiner n 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 ☐ Yes 2XXNo 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural" Completed 3 ₹ Widowed 4 □ Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Washington D.C. Elementary/Secondary (0-12) College (1-4 or 5+) Social Worker Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Alex Adin Tec1a Jesikowska 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5802 Valerian Lane, Rockville, MD Meredith Weiser / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2XXCremation 3 ☐ Removal from State Chesapeake Crematory 12/13/2012 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice Rapp Funeral and Cremation Services Ollins 933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ RESPIRATOR disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ENA Sequentially list conditions. Examiner cause. Enter Underlying Cause (Disease or injury METHSTATIC that initiated events Due to (or as a consequence of resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be ex attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year 9 Unknown Unknown signed by the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Director: After this certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital Other: 9 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred iniury work?
1 \(\sum \) Yes 2 \(\sum \) No Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined within 24 hours a To the Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier

4 State

Registrar DHMH 17 Rev 06-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

UNEGISU, MD

31. Date filed (Month, Day, Year)

U71264

7350 VAN DUSEN RD STE 220 LAWREL MD

29d. Date signed (Month, Day, Year)

ORIGINAL

12-09	110
Gloria	Williams

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

loria Williams		State of Maryland / Department of Heal 1- For State Certificate of Deal		/giene Reg	201	2 40629
Physiciar	1/	Registrar		2. Date of Death		3. Time of Death
Medical Examin		4a. Facility Name (if not institution, give street and number) 4b. City.	Town, or Location of Death	Month I November 3	30, 2012 4c. County of Deat	1545 hrs
		1726 Montpelier Street Baltin			NA	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Uno Monti	der 1 Year If Under 24Hrs. hs Days Hours Min.	8. Date of Birth	(MM/DD/YYYY) 9. Bi Forei	rthplace (State or gn
Director	C	24-64-4822 1 M 2 F 35 Yrs.	la Days Hours Will.	10/15/1	1957 C	ountry)
ku w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
È	٦	MD N/A Baltimore				1 Yes 2 No
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21215-0036 uld be filed within 72 hou Mental Hygiene. marked other than "nat		17. Father's Name (First, Middle, Last)	18.Mother's Name	0.0	- A 1 1-	
Ore, MD 21215-0036 ges I and 2 should be filed within 72 hours after death with the Maryland t of Health and Mental Hygiene. If Ikem 27 is marked other than "natural", nr items 23a or 28a-f shutther traumatic event, the Medical Examiner must be mutified at once	e Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addres	SS (Street and Number or F		Willams per, City or Town, Stat	e, Zip Code)
imore, MD 2 Pages 1 and 2 shour nent of Health and N and: If item 27 is a or or or nether traumatic		Marcus Williams-Brother 5601 t	Burtis AV		Himore, A	10 21207
of Hea	-	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Na crematory or other place)	e)	Date	20c. Location - City o	1 Town, State
E 4 5 5 1	-	4 Donation 5 Other Specify: King Milmon 21. Signature of Funeral Service Licensee 22. Name an	a Pay(12)	7/2012	Kandalls	town, MI)
Balti permit. Departir Imports	1	Brank Meller 1101 B	E. North Av	e. Bal	timore MC	21202
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sit d	Xan	events resulting in death) Last Due to (or as a consequence of):				
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760, rate be physicia he buria					23d. Date of delive	
Box 68760, e death certificate be the attending physic of for use as the bured	cian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (Sp		ancy	Month	Day Year
Box te death the atte	Physician/N	1 Yes 2 No 9 Unknown g Unknown				
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F Vit		examiner? 1 Ves 2 No 1 No Hospital: 1 Inpatient 2 ER/Outpatient 3 27. Manner of Death 28a. Date of Injury 28b. Time of Injury	DOA Other Nursi 28c. Injury at Work?		Residence 6 🗹 Oth	er: Scene
ion of tending Ph (cath.	ë	1 X Natural 5 Pending	1 Yes 2 No	254. 255		
ViSiC ar Atte fter dez Directo	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factor	ory, office building, etc.	28f. Location (S or Town, St		Rural Route Number, City
Divis Bital nr At hours after d neral Direct	Set	4 Homicide determined (Specify)				
Division of Vital Records, P.O. Box 68760, To the Hospital not Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at to the composition one) Medical Examiner: On the basis of examination and/or investigation, in the composition of th	he time, date and place, an my opinion, death occurred	a due to the cause at the time, date a	e(s) and manner as st and place, and due to	ated. the cause(s)
Son Sign	Mec	and manner stated. 29b. Sonature and title of certifier	29c. License number		29d. Date signed (M	
	1 0	(the when	O.C.M.E.		December 1, 2	012
R		30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 900 W. Baltimo	re Street, Baltimore,	MD 21223		
	ate	31. Date filed (Month Day, Year) 32 Registrar's Signatur		-		
Reaist	rar	DECT TOTAL CONTROL OF THE				

UUNIC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Reg. No 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 1, 2012 1:45 A M December Wilson Frederick E. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Aspenwood Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours Director 234-38-8255 1 🛛 M 2 🗆 F Nov 15, 1925 Maryland 87 Usual Residence of Deced or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits be notified at Director 1 Tes 2 No Savannah GA Chatham 10e. Street and Number 10g. Citizen of What Country? 23a Funeral ral", or items 23. Examiner must United States 1 Starbridge Court 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ian "natural", o 1 ☐ Yes 2X No Specify Specify: 3 X Widowed 4 □ Divorced Completed White Year or Dates. 1944-46 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) during most of working marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Insurance 4 Insurance Agent traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H မ Carrie Alice Phares Frederick Emmett Wilson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1 and 2 s of Health item 27 11111 Easecrest Drive Silver Spring, MD 20902 Malcolm Wilson / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or o once, 5 1 Burial 2 X Cremation 3 Removal from State Journey Crematory 12/14/2012 4 Donation 5 Other (Specify) Woodbine, Maryland Signature of Funeral Service License Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 -MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Dementia Medical Due to (or as a consequence of): Examiner Parkinson's Disease Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-transit Failure to Thrive that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Dav Year 1 Yes 2 9 Unknown 2 🗌 No the a 9 Unknown detached s been signed by til should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Rrobably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 🗆 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Assisted Living Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 ☐ Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဂ funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🛛 Natural work' 5 Pendina death. 1 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760 P.0. Records, Director: After this certificate has Division of Vital Hospital or Attending filled in by the within 24 hours a

State

Registrar DHMH 17 Rev 06-2011

Medical

29a. Certifier (Check

29b. Signature and title of

Kaveh Sadeghi 31. Date filed (Month, Day 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12150

ORIGINAL

Annapolis Rd.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

#308 Glenn Dale, MD 20769

29d. Date signed (Month, Day, Year)

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 13, 2012 6:30 A M Martell Tepper Weil Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Renaissance Gardens Silver Spring If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 260-22-3937 Director 1 M 2 X F Yrs 1919 Georgia Jan 18, 93 r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No MD Montgomery Silver Spring 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 20904 United States 3116 Gracefield Road VP409 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔯 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Retail Sales Owner permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If itam 27 Is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Tepper Anna Aronowitz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) McLean, VA 22101 6515 El Nido Dr. <u>Richard Tepper Weil / Son</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Flinal Journey Crematory 12/15/2012 Woodbine, Maryland Sign we of Funeral Service Lice Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death
Vears Immediate Cause (Final Physician 3 Lung Cancer with Metastases disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Undarbing Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): been signed by the attending physiclan and should be detached for use as the burlal-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔀 No 5 Other (specify) Day 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 No Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy performe Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) examiner? Assisted Living Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 2X No 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred s efter dea. al Director: Afte 1 🛮 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours efter

To the Funeral Directory

Completely filled in b Hospital Medical 29a. Certifier 1 🛄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month. Day, Year, 30. Name and address of person who completed cause of death (term 23a) (Type, Print) 10V 3110 Gracefield Rd. Julain¢ Harding Silver Spring, MD 20904

Registrar

State

31. Date filed (Month, Day, Year)

4 2012

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 40632 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Robert L. Woolf, III December 9:04 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 13039 Beaver Dam Road Cockeysville Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Director 220-54-5986 51 1 X M 2 D F 6/30/1961 Maryland Usual Residence of Deced and 2 should be filed within remove.
I health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28e-f show
Item 27 is marked other than "hatural", or items 23a or 28e-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Maryland Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13039 21030 Beaver Dam Road U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married 2 Married Black, White, etc. ğ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Contractor Landscaping Comp. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sadie Frances Warfield Woolf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffrey S. Woolf / brother 16907 Falls Road Upperco, Maryland 21155 permit. Page 1 and 2 Department of Healt Importent: If Item 2: any Injury or other to 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Hilltop Serv. Corp. 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 12/13/2012 Towson, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Suicide selfint (runsho disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of: Attending Physician: The law requires that the death certificate be executed sician and burial-trans resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death Year sate has been signed by the a page 2 should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 After this certificate funeral director, pag 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\triangle \) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 Yes 2 □ No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Self whiched 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work? 1 ☐ Yes 2 🔀 No 2104PM gunshotwound s efter death.

I Director: A
od in by the fi 2/9/2012 Investigation 10 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) f. Location (Street and Number or Rural Route Number, City or Town, State) / 3039 Bacus Dam Rd determined 24 hours efter Funeral Dire letely filled in b ō me Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completely f 2 X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 866

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Iviary		rtificate of De			eg. No.			
	Physicia	n/	1. Decedent's Name (First, Middle, La					2. Date of Death		2 3. Time of Togath		
	Medic	al	Clarence Walte			T., ., .		Decembe:	per 10, 2012 2:25 P M			
	Examin	er	4a. Facility Name (if not institution, give Alice Manor Nu			4b. City, Town, or Lo			4c. County of D	Death		
	Funeral		5. Social Security Number 6. S	iex 7. Age (In	yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9.	Birthplace (State or Foreign		
	Director		495-38-6833	Ж м 2 □ F	76 Yrs.	s. Months Days Hours Min. Sep. 6, 1936 Missouri						
	nd how at	ž	Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or L	ocation				10d. Inside City Limits		
	faryla Ba-f s tified	ecto	Maryland Harford		Joppa					1 ☐ Yes 2 🔼 No		
	the Na or 29	٥	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What	: Country?		
	h with	Funeral Director	614 Falconbridg	e Drive		21085			USA			
	r deat	/ Fu	11. Marital Status 1 ☐ Never Married 2 ☒ Married	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,	anic Origin? (Spe Mexican, Puerto I	cify Yes or No- Rican, etc.)		merican Indian, /hite, etc.		
980	safte ral", o Exam	ed by	3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 No If Yes, Give Year or Dates.		1 ☐ Yes 2 🔀 No	Specify:		Specify:	White		
2-0	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gi		16a. Dece	edent's Usual Occupation	on ina most of working	na	16b. Kind of Busine	ess Industry		
12	thin 7 ane. than he Me	Som	Elementary/Seconday (0-12)	College (1-4 or 5+)	life.	no NOT use retired) hasing Spe			Covernme	nt Contractor		
ر م	filed wi al Hygie d other event, t	Be	17. Father's Name (First, Middle, Last)	5	Turc		8. Mother's Name			THE CONTENACTOR		
/lan	d be fi vental arked ttic ev	Jesse Edward Wilson Edna Marie Paddoc										
lan	The state The											
e,	and 2 Health em 27 ther t		Margaret C. Wils 20a. Method of Disposition		0b. Place of Disp	Falconbrid			Maryland 20c. Location - City			
Baltimore, Maryland 21215-0036	Page 1 nent of ant: If it ury or o		1 ☐ Burial 2 ☆ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of Cont	Removal from State	cemetery, cre	ematory or other place) 1 SVCs, 11	i		•			
äŧ	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licen			22. Name and Address						
m	permi Depar Impor any ir		Staly an	uc ly		1317 Cokes						
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	one cause on each line.						Approximate Interval Between		
-	Phylician Medical		Immediate Cause (Final disease or condition resulting in death)	a. Con	prono	acting	Pi Sea	re		Onset and Death		
	Examiner		resulting in deathy	Due to (or as a cor	nsequence of):	Obs brue	emo Ri	Ammo	ry n. Con			
		ner	Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a cor	nsequence of):	0 /3 .0	-11-6-0	Carre	Jaco	K		
of	outed nd ransit	Examiner	Cause (Disease or linjury that initiated events		year je	ndus						
5,	death certificate be executed ne attending physician and ed for use as the burial-transit	al E	resulting in death) Last	Due to (or as a cor	íséquence of):							
Box 68760	cate b physi	Physician/Medical		d								
98	eath certifica attending p	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr					23d. Date of	delivery		
Box	death ne atte ed for	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown		Ctopic pregnancy Other (specify)			Month	Day Year		
P.0.	at the d by the etache	Phy	9 ☐ Unknown Part II. Other significant conditions of		ot resulting in the	underlying cause giver	n in Part I.	23a Did tob	acco use contribut	e to the cause of death?		
S, D	requires that the de been signed by the s should be detached	d by				,				Probably 4 Unknown		
ord	requi	Completed						24a. Was an	24b. Were	autopsy findings available		
Šeč	he lav te has	omo		***				autopsy perform	ned? death	to completion of cause of n? Yes 2 □ No		
<u>a</u>	sian: T ertifica ctor, p	Be C	25. Was case referred to medical examiner?				e of Death (Check			100 2 2 10		
\equiv	Physic this co	မ	1 Yes 2 No 27. Manner of Death		2 ER/Outpation	. 1			nce 6 Other (S	pecify)		
D O	ding I th. After funer	cate	Natural 5 Pending 2 Accident Investigatio	28a. Date of injury (Month, Day, Yea		work?	es 2 \square No	28d. Describe hov	v injury occurred			
Division of Vital Records,	Atten er dea ector: by the	Certificate:	3 Suicide 6 Could not to determined	28e. Place of Injury -						Rural Route Number,		
<u>≤</u>	ital or Ins aftu ral Dir lled in			building, etc. (Sp			1	City or Town,				
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.	Medical	(Check 2 L Medical Exam		nation and/or inve	stigation, in my opinion,	death occurred at	the time, date and	l place, and due to t	he cause(s) and manner stated.		
	Fo the within Fo the comple	Σ	only one) 3 ☐ Certifying Nur 29b. Signature and title of defitifier	se Practioner: To the best		29c. License n			ause(s) and manner			
			▶ th	M.D	•	D7253	6		12-10-2	012		
	kof,		30. Name and address of person who	completed cause of death	(Item 23a) (Type,	Print	Siral	- Luit	1308	Bally nure Mg		
	Stat Registra		31. Date filed (Month, Day, Year) DEC 1 4 2012	32. Registrar's	Signatur and	,						
			W									

CLARENCE WILSON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19b Per FH G934 12/14/2012 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day WEINER 6:40 AM SUSAN Decembe 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Sinai Baltimore Baltimore of N/A Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Days Director 220-64-9091 1 □ M 2 🗓 F 59 03/30/1953 MD permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exeminer must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director BALTIMORE BALTIMORE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21209 USA 6632 CHIPPEWA DRIVE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 X Married à 1 Yes 2 No Specify: Specify: WHITE 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) MARYLAND STATE Elementary/Secondary (0-12) College (1-4 or 5+) DISABILITY ASSESSMENT GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည ALBERT LEO MIRIAM LATTIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Bural Route Number, City or Town, State, Zip Code) STEPHEN WEINER / HUSBAND 6632 CHIPPEWA DRJIVE, BALTIMORE, MD 21209 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OHEB SHALOM MEM.PARK 12/13/2012 REISTERSTOWN, MD of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Medical Examine To the Hospital or Attending Physician: The law requires thet the deeth certificate be executed within 24 hours after death.

To the Zuneral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burlal-transit

Physician/ Examiner

Baltimore, Maryland 21215-0036

Completed by Physician/Medical æ Certificate: To

Medical

29b. Signature and title of certifie

Omar

31. Date filed (Month, Day, Year,

hokir

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Sinai Hospital of

82. Registrar's Signature

Division of Vital Records, P.O. Box 68760

shock, or heart failure. List only one	cations that caused the death. Do not enter the mode of dying, such as cardiac e cause on each line.	or respiratory arrest,	Approximate Interval Between
Immediate Cause (Final disease or condition resulting in death)	Due to the as a consequence of:	4	Onset and Death
Sequentially list conditions, in any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):	uma	1 year llocorth
issually in deality East	4		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No g ☐ Unknown	3c. If yes, outcome of pregnancy 1		23d. Date of delivery Month Day Year
thromboutopenia,	tributing to death but not resulting in the underlying cause given in Part I.	1 ☐ Yes	use contribute to the cause of death? 2 □ No 3 □ Probably 4 🖾 Unknown
vein thrombesis		24a. Was an autopsy performed?	
25. Was case referred to medical	26. Place of Death (Chec	k only one)	
examiner? 1 ☐ Yes 2 🛣 No	ospital: 1 🕱 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA Other: 4 🗀 Nursing H	ome 5 Residence	6 ☐ Other (Specify)
27. Manner of Death 1 Natural 2 Accident Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury injury 28c. Injury at work? 1 □ Yes 2 □ No	28d. Describe how inju	
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street a City or Town, Stat	nd Number or Rural Route Number, e)
(Check 2 Medical Examin	cian: To the best of my knowledge, death occurred at the time, date and place, ter: On the basis of examination and/or investigation, in my opinion, death occurred at Practitioner: To the best of my knowledge, death occurred at the time, date and p	at the time, date and place	e, and due to the cause(s) and manner stated

29c. License number

P27660

2461

29d. Date signed (Month, Day, Year)

. Baltimore

11,2012

December

w Belvelez Ave

State Registrar Bultimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ANNA WELLING 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GOOD SAMARITAN HOSPITAL BALTMORE RATTIMORE Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Min. Days (Month, Day, Year) 02/05/1961 Hours Country) (,220-82-8209 **Director** 1 🗆 M 2 🗷 F MD Yrs Usual Residence of Decedent items 23a or 28a-f shov 10b. County 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Parkville MD Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21234 USA 8729 Loch Bend Drive Apt 149 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 ☐XNo Specify: 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Office Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Suman Donna Marie Stubel 2 Andrew Stubel permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Smith Auth Agent 8729 Loch Bend Drive Apt 149 Parkville MD 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other pl Atlantic Crem 1 D Burial 2 X Cremation 3 Removal from State 12/8/2012 Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover MD low 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final GASTOINIESTINA Onset and Death Physician/ House Medical resulting in death) Due to (or as a consequence of) Examiner OMIS ALUITE ITEPMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? BREADT CANCER 1, ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? CIRRITOSIS 24a. Was an autopsy 2 🗹 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 Ø No Other: ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending injury 1 ☐ Yes 2 ☐ No by the 1 Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide within 24 hours after
To the Funeral Direct
completely filled in b City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO 2012 RPS 000

State Registrar BUDD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

hotten

MO

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Gordon Joseph Young Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner AIMOR If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) If Unde 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) Days 213-01-2505 Months Hours Director 1 ፟M 2 □ F Fe. 18, 1916 Maryland 96 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumetic event, the Medical Examiner must be notified ** once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 Yes 2 X No Baltimore Cockeysville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21030 USA 223 Warren Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in LLS 11. Marital Status 14 Race - American Indian Armed Forces?

1 🖾 Yes 2 🗌 No Black, White, etc. 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates. WWII 1 ☐ Yes 2 Ø No Specify. Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Auto Technician Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna Horstman Joseph Thomas Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma Elizabeth Brian-Sister 200 Glenmore Avenue; Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Parkwood Cemetery 12/15/2012 Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral 53 1001 1630 Edmondson Avenue: Catonsvill 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner 500 Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. use as the burial-tran within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 Yes 2 9 Unknown Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed' 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be Division of Vital 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မူ 1 Ninpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d, Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) eted cause of death (Item 23a) (Type, Print) 0 Day, 32. Registrar's State 4 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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		State Registrar	Cer	tificate of D	eath	F	Reg. No.Z U	12	40637
Physicia Medic		1. Decedent's Name (First, Middle, Last) Barbara Youn	9			2. Date of Dea	Day	Year 72	3. Time of Death
Examin		4a. Facility Name (if not institution, give street and number)	Modral	4b. City, Town, ard	Location of Death		4c. County	of Death	Described
Funeral Director			e (In yrs. last birthday)	0.0	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	9. Birthpl Counti	
	r	Usual Residence of Decedent 10a. State 10b. County	69 Yrs.	cation		12-23	-1942		RYLAND Od. Inside City Limits
//arylar //8a-f sl	Director	MD. N/A	BALTIM						1X□ Yes 2 □ No
ith the Manager 23a or 2		10e. Street and Number 31 UPMANOR RD.		10f. Zip Code 21229			10g. Citizen of V	What Count	ry?
re, Maryland 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	/ Funeral	11. Marital Status 12. Was Decedent E		Was Decedent of His f Yes, specify Cuban	panic Origin? (Spec , Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Rac	e - America	
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exami	ted by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.		1 ☐ Yes 2 🛣 No				BLAC	
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d 21 ed with Hygien other th	Be Co	Elementary/Secondary (0-12) College (1-4 or 5 - 12 - 2 - 17. Father's Name (First, Middle, Last)	LA	AB TECH	18. Mother's Name	(First Middle II	UNILE		
Maryland & should be filed wand Mental Hyg 7 is marked othe raumatic event,	2	EDWARD L. BYRD				TE YOUN			
Mar 2 shou Ith and 27 is m traum		19a. Informant's Name/Relationship (Type, Print)	T	ng Address (Street ar JPMANOR RD					ode)
Ore, IM of Health if item 27		WALTER YOUNG (HUSBAND) 20a. Method of Disposition 1 □ Burial	20b. Place of Dispo		D	ate FIA	20c. Location -		vn, State
Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or other		4 Donation 5 又Other (Specify NTOMBMEN	GARRISON	FOREST VE	TERANS 1	2-17-20	12 OWIN	GS MI	LLS, MD.
balti permit. Departin Importa any inju		21. Signature of Fundral Service Licensee TONATHAN	D, HIBN R						, P.A. YLAND 21217
pull de said		23a. Part/1. Enter the disease, or complications that caused shot, or heart failure. List only one cause in each line Immediate Cause (Final	the death. Do not ente	_)	1	respiratory arre	est,		Approximate Interval Between Onset and Death
Physician Medical Examiner		disease or condition	consequence of):	EMBO	11314			-1	
35 PAS	ner	Sequentially list conditions, if a y, leading to immediate cause. Enter Underlying	cunsequence of;					3.0	
scuted and -transit	Examiner	Cause (Disease or injury that initiated events c.	a consequence of):						
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VITAII ysician is certifi directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital:	ent 2 ER/Outpatier	Other	ce of Death (Check		ence 6 \(\text{Other}	er (Specify)	-
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DIVISION OF VITAL RECORDS, lal or Attending Physician: The law requires rs after death. In Director. After this certificate has been signed in by the funeral director, page 2 should be an in by the funeral director, page 2 should be a signed or a should be	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Inju	ry - At home, farm, stre . (Specify)			28f. Location (St City or Town	reet and Number, State)	er or Rural F	Route Number,
Dispital obspital of hours a nueral Dispital Dis	Medical (29a. Certifier 1 Certifying Physician: To the best of							
DIVISION OF VITAL RECONDS, To the Hospital or Attending Physician: The law requires within 24 hours after death. To the Funeral Director. After this certificate has been sign completely filled in by the funeral director, page 2 should be	Mec	(Check only one) 3 Certifying Nurse Practitioner: To the 29b. Signature and title of certifying (Check only one) 3 Certifying Nurse Practitioner: To the 29b. Signature and title of certifier			e time, date and plac	e, and due to th		nanner as st	ated.
F × F ō		· SC/JUMI							
31/11/		30. Name and address of person who completed cause of de	eath (Item 23a) (Type, P	Hospin	tal pri	e, 61	184 BU	mie,	Mariland
Stat Registra	e ir	31. Date filed (Month, Day, Year) DEC 1 4 2012	r's Signature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Manth/23/2012 Edna Luellen Archer 12:06A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Southern Maryland Hospital Prince George's Clinton Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8 Date of Birth 6. Sex **Funeral** Days (Month, Day, Year) Director 578-78-0961 1 🗆 M 2 🕱 F 91 01/16/1921 Guyana Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Director or then "natural", or items 23e or 28a-fe the Wedloal Examiner must be notified 1√X Yes 2 □ No Washington, DC 10e. Street and Number 10g. Citizen of What Country? 2046 34th Street S.E. 20020 USA Page 1 end 2 should be filed within 72 hours after death v ment of Heelth end Mental Hygiene. ent: if item 27 is merked other then "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc δ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 XNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: Black Completed 3 → Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Seamstress Retail Department of Health end Mental Hygi importent: if Item 27 is merked other eny injury or other traumetic event, ODGS. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Edward McDonald Featherstone Maude Mandeville 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Archer 34th Street SE Washington, DC / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1XX Burial 2 Cremation 3 Removal from State 12/3/2012 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Mem. Cem. 22. Name and Address of Facility George P. Kalas Funeral Home PA 21. Signature of Funeral Service Licenses 6160 Oxon Hill Rd. Oxon Hill, Maryland 23. Part 1. Enter the diseas, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cluse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Acute Atherosclevona Carchovascular dis ease disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of,: ettending physicien end d for use es the buriel-trensif Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1. ☐ Yes 2 ☐ No Month Day been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b director, pege 2 s autopsy ₽ No 1 ☐ Yes 2 No ☐ Yes **Division of Vital** To the Hospital or Attending Physicien: within 24 hours effer death.

To the Funerel Director: After this certifical completely filled in by the funeral director. 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Certificate: To Other: 2 🗀 No 1 Inpatient 2 PAR/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 \square Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4
Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 50689 11/23/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A HILK MAHATAN (D. SULMEN MAY/AND center Shwalts

Records, P.O. Box 68760

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month.

Road

Clinton

MD

7503

32. Registrar's Signature

Registrar DHMH 17 Rev 06-2011

State

29b. Signature and title of certifier

in

Ludwig

31. Date filed (Month, Day, Year)

J.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IIIM.D.

32. Registrar's Signature

Egleseder,

Baltimore, Maryland 21215-0036

Records, P.O. Box 68760

Division of Vital

29c. License number

503 Cynwood Drive

29d. Date signed (Month,

21601

Easton, MD

Day, Year)

12-08688									
Jerry	Joseph	Abbot							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Jerry Joseph Abbo	1	- For State	tate of Mai	ryland /	-	artment o <i>tificate</i> o			Ment	al Hy	_	Reg. No.	20	10	1.061
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	4							Town, or Londridge	ocation of			4c. County of Death Dorchester			
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2 hours after death wi "natural", or items Examiner must be sted by Funera		21 Sugar Drive 11. Marital Status 1 Never Married 2 N	12. Was Decedent Ev Armed Forces?		If Ye		21631 s Decedent of Hispanic Origin? (Spees, specify Cuban, Mexican, Puerto F				SA 14. Race - A White, 6		an Indian, Black,		
		3 X Widowed 4 Dir 15. Decedent's Education (Spe	1 X Y vorced If Yes, Given or Dates: acify only highest	re Year 196		16a. Deceder	nt's Usua		n (Give ki			16b.	Specify: Kind of Busir		hite
	mpiete	Elementary/Secondary (0-12)		ege (1-4 or 5+	·)	Sales			tativ	ve				ant	Equipment
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	8	Reginald Edward Abbott Louise Muir							State	Zin Code)					
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Baltimore, permit. Pages I an Department of Hee Important: If itel injury or other tr		20a, Method of Disposition 1 X Burial 2 Crematio 4 Donation 5 Other S	Specify:	val from State	9 (Place of Dispos crematory or ot t New M	her plac	e)	·	11/2	Date 20/2012		Location - C st New	•	rown, State
	d	21. Signature of Funeral Service	Jo.	Solle	w	Ze: 10	ller 6 Ma	Address of Fune	ral l reet	Home Ea	P. 0	. Bo	ox 207 rket,	MD	21631
Physician /Medical xaminer		23a. Part I. Enter the disease, of dailure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line a. Rupture	ed Abdomi	inal Ad	ortic Aneury		or aying, s	uch as ca	rdiac of	respiratory ar	rest, sn	ock, or heart		Approximate Interval Between Onset and Death
		Sequentially list conditions,	_{b.} Hyperte	e to (or as a consequence of): /pertensive Atherosclerotic Cardiovascular Disease											
sd Isit		lf arry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Unit to (or as a consequence of): Due to (or as a consequence of):													
0, the executed sician and burial - transit	edical	UNPENDED	dAMEND)ED							·				
ox 6876(sath certificate attending physicates as the b	šΙΙ	IF FEMALE: 3b. Was decedent pregnant in t past 12 months? 1 Yes 2 No 9 Un	he 1 L 4 P	yes, outcome live birth Pregnant at tir		2 Fe	etal death		Ectopic	pregnar	ncy	23	d. Date of de Month	•	ay Year
<u> </u>	2	Part II. Other significant condi	iditions contributing to death but not resulting in the underlying cause given in Part I.						t I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ✓ No 3 Probably 4 Unknown					
Division of Vital Records, P.O. as or attending Physician: The law requires that the ras after death. **All Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.	Completed	24a. Was an autopsy findings available autopsy prior to completion of cause of performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No												empletion of cause of	
Vital Recypican: The his certificate director, page	e i	25. Was case referred to medical examiner?	Hospital:	Innation	2 1	ER/Outpatient	3□	26.Place o	ther -			l Bonide	ence 6	Othor	
ion of Vi tending Physicath. ior: After this the funeral dir	2 :uoi		28a. [Date of Injury Month, Day,Yea	,	28b. Time of I		28c. Injury		· 1	28d. Describe				
Division of Vital the Hospital or Attending Physician: thin 24 hours after death. The Funeral Director: After this certific npletely filled in by the funeral director, filed in the funeral director director.		2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number or Rural Ru									al Route Number, City				
To the Hospital within 24 hours To the Funeral completely filled	<u>ਰ</u> ਹਿ	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. One) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
	2	29b. Signature and title of certifi	er - Ha	lla	v		29	O.C.M					Date signed vember 16		th, Day, Year)
5+150	3	30. Name and address of person Carol H. Allan, MD	n who completed Assistant Mo		,	,	- Baltimo	ore Stree	et, Baltir	more,	MD 21223				
Stat Registra	~	31. Date filed (Month, Day, Year)		2. Registrar's	Signatu	, par	KN								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 40641 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day)00+h 2012 December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Cit Itospital Johns timore topkins 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) JAN 24, 1953 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Days 222-36-8618 Director 59 DELAWARE 1 XM 2 □ F Usual Residence of Decedent ii Hygiana. I other than "netural", or itama 23a or 28e-f ehow vent, tra Medical Examinar must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director DE SUSSEX MILFORD 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7327 NORTH UNION CHURCH ROAD 19963 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. δ 1 Never Married 2 X Married Maryland 21215-0036 WHITE If Yes, Give 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) PRODUCTION MANUFACTURER a 1 end 2 should be filed wir of Health end Mantei Hygia If Item 27 ie marked othar ir other traumatic event, II Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည WEBB **GENEVA** ROBERT s. BOOTH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 7327 NORTH UNION CHURCH ROAD, MILFORD, DE 19963 DEBORAH BOOTH Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Paga 1 e Department of H Important: If ite eny Injury or ot 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) 12/10/12 MILLSBORO, DE FIRST STATE CREMATION ONIR 21. Signature of Fune al Service Licenses 22. Name and Address of Facility SHORT FUNERAL SERVICES, PO BOX 416 FEDERAL ST MILTON DE 19968 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ naemi Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examin attending physician and for use as the buriai-transit that the death cartificate be axacuted that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year ad by the a datached 1 9 Unknown P.0. s bean signad t should ba dat Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 or Attending Physician: The lew requires t Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cata has ; autopsy 2 🗌 No 1 Yes **Division of Vital** funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 2 2 No 1 Pinpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 24 hours aftar daath. • Funarai Director: Afta stataiy fillad in by the fur 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital o within 24 hours af To the Funaral Di Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) December 5,2012 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Orleans St-Baltimore, MD. 21287 Soonie Wells 31. Date filed (Month, Day, Year)

DEC 1 4 2012 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. s Name (First, Middle, L'ast 2. Date of Death Physician/ Month 2103 οŪ 2012 Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death lan arcal salti Mer 哒一 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Months Days -485 Director 1 M 2 - F 58 Washington, D.E ed other then "naturel", or items 23a or 28a-f show event, the Medical Evanning must be notified at 10a. State 10c. City, Town or Location within 72 hours efter death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No Dorcheste Hurlock 10f. Zip Code 10g. Citizen of What Country? Funeral borne Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Mantal Status 12. Was Decedent Ever in U.S. Race - American Indian, Armed Forces? Black, White, etc. 1 M Never Married 2 ☐ Married Š Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 Department of Health end Mental Hygiene. Importent: If item 27 Is marked other then "n, eny injury or other treumetic event, the Market one." (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) arpenter Housing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Beebe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) - Daughter Cambridge, Md. 21
Date 20c. Location - City or Town, State Sabrina Hudson Road 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State Direct Crematory LLC 4 Donation 5 Other (Specify) 12-12-2012 Dover, Delaware 21. Signature of uneral Service Lix nsee 22. Name and A dress of Facility Bennie Smith Funeral Home 524 Race Street, Cambridge, Md. 21613 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on caused the death. Do not enter the mode of dying, such as cardiac or respiratory arre Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ DXIV Medical resulting in death) sequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit or Attending Physician: The lew requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE f yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.
Funeral Director: After this certificate has autopsy performe Yes 2 No 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ٥ 2 No 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Division 2 Accident 1 🗌 Yes 2 🗌 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F only one) 29b. Signature and title of certifier 169904169 04/2012

Registrar
DHMH 17 Rev 06-2011

State

Rowan

31. Date filed (Month, Day, Year)
DEC 1 4 2012

(areene

21201

30. Name and address of gerson who completed cause of death (Item 23a) (Type, Print)

22

32. Registrar's Signature

unell

Amend #1 & 26 per Phy. State of Maryland / Department of Health and Mental Hygiene 40643 AA Co Health Dept State Registrar Certificate of Death 11/27/12 lo 1. Decedent's Name (First, Middle, Last) 2. Date of Death Gefard Clayton Pogart Physician/ Month Day / 45AM Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's 12804 Cherrywood Lane Bowie 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Hours 103-16-5821 Director 1**X X**M 2 □ F Sept. 23,1924 88 New York Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director NY St. Lawrence Cranberry Lake 1 Ves 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12927 USA 607 Columbian Road 12. Was Decedent Ever in U.S.
Armed Forces?
1 ⚠ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married <u>^</u> Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates. Army Specify: White 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the N General Motors Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frank John Bogart Freida Matilda Hahn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 607 Columbian Road, Cranberry Lake, NY 12927 Jeanne R. Bogart/Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Metro Crematory 1 Burial 2 X Cremation 3 Removal from State Nov.24,2012 Baltimore, MD 4 ☐ Donation 5 1 Other (Specify) 21. Signature of Funeral S 22. Name and Address of Facility Beall Funeral Home vice Licensee 6512 NW Crain Hwy, Bowie, MD 20715 Part 1. Enter the disease, or conditications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 F FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) ed by the at detached for g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig ; page 2 should b 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy performed? Yes 2 No 1 Yes 2 No æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Treeide ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 6 Tother (Specify) Son's Home within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral 27. Manner Jath 28b. Time of 28c. Injury at work? 1 \(\text{Yes} \) 2 \(\text{No} \) 28a. Date of injury (Month, Day, Year) Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 3 10 7 41 Defense Highway 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 0110 Annapolis, mp 2 140 31. Date filed (Month, Day, Year) 22. Registrar's Signature State NOV 2 7 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 2 State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10:35 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gambrills Anne Arundel 2441 Bell Branch Rd. If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 579-12-1869 Director 1 M 2 X F 28,1915 No. Carolina Sept. Usual Residence of Decedent ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the <u>Medical Examiner must be notified at</u> 10b. Count 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🎦 No MD Crofton Anne Arundel 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 21114 USA 2508 Log Mill Ct. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married Þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No If Yes, Give Specify: White 3 Nidowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event straum. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Jones Alexander Ester Deal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2441 Bell Branch Rd., Wallace L. Bell / Gambrills, MD 21054 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery: 11/30/2012 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD 21. Signature of Funeral Service Licenses Beall Funeral Home 22. Name and Address of Facility 6512 NW Crain Hwy., Bowie, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of using, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence or). the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi Cause (Disease or injury that initiated events attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Pregnant at time of death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Son'S home 2 **N**0 မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 🗌 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
Certifying Nurse Practitioner: To the past of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 445 Delense Hohway and address of person who completed cause f death (Item 23a) (Type, Print) 10/1 Anna polis 31. Date filed (Month, Day, Year) NOV 2 7 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 40645 State of Maryland / Department of Health and Mental Hygiene 1 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Pan Boldon Рм 5:08 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1851 Kings Place Crofton Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Hours Min. 557-72-6034 1 M 2 D F 63 Director Illinois Usual Residence of Dece permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Crofton 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1851 Kings Place 21114 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 私 Yes 2 □ No If Yes, Give Year or Dates Yietnam Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Engineer NASA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Leroy Boldon Claudia Charlesworth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan M. Boldon / Spouse 1851 Kings Place, Crofton. MD21114 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 11/20/2012 Baltimore, MD 4 Donation 5 Other (Specify) Signature of Licensee 22, Name and Address of Facility Beall Funeral Home Bowie, MD 6512 NW Crain Hwy.. 20715 Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final letastatic Physician umsmall cell disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events attending physician and I for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Month Day Year 4 Pregnant at time of death 9 Unknown 1 Yes 2 L 9 Unknown Yes 2 No been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director. After this certificate has autopsy performed Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes ☐ Natural☐ Accident 5 Pending 2 🗌 No Investigation Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 [only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year,

5 W

State

Registrar

31. Date filed (Month, Day, Year) NOV 2 7 2012

Name and address of person who completed cause of death (Item 23a) (Type, Print)

polica

32. Jegistrar's Signature

10vember 20,2012

			State of Maryland / De		Mental Hygiene									
			Registral	ertificate of Death	Reg. No	·2012,40646,								
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Virginia A. Brown		2. Date of Death Month Confidence A confidence 2. Date of Death	3. Time of Death 12:18 PM								
	Examin		4a. Facility Name (if not institution, give street and number) Doctor's Hospital	4b. City, Town, or Location of Death Lanham		c. County of Death rince George's								
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)								
	Director		578-40-8650 1 □ M 2 13 F 80 Yrs.		Nov. 21, 19	932 New York								
	rland f shov d at	tor	10a. State 10b. County 10c. City, Town or	ocation		10d. Inside City Limits								
	e Man r 28a- notifie	Director	MD Prince George's Lanham 10e. Street and Number	Lace 7: 0 1		1 ☐ Yes 2 🔀 No								
	vith th		9216 Rolling View Dr.	10f. Zip Code 20706	USA	itizen of What Country?								
	death v	Funeral		J. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,								
036	permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates.	1 ☐ Yes 2 🛣 No Specify:	Trican, etc./	Black, White, etc. Specify: White								
2-0	2 hour "natu	plete	15. Decedent's Education 16a. Dec	edent's Usual Occupation e kind of work done during most of work	kina 16b. k	Kind of Business/Industry								
121	ithin 7 ene. r than	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	DO NOT use retired) memaker		n Home								
Baltimore, Maryland 21215-0036	filed w al Hygi d othe	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nan	ne (First, Middle, Maiden	Surname)								
ryla	uld be d Ment marke natic (입	Joseph Patrick Connors	Margare										
Ma	12 sho lith and 27 is r		· · · · · · · · · · · · · · · · · ·	iling Address (Street and Number or Rui $9216 ext{Rolling View}]$										
ore,	of Health ar of Health ar fitem 27 is rother trau		20a. Method of Disposition 20b. Place of Dis	position (Name of ematory or other place)		ocation - City or Town, State								
ti m	tment tant: I		4 □ Donation 5 □ Other (Specify) Resurred	ction Cem. 11/20		inton, MD								
Bal	permit Depar Impor any in	ral Home MD 20715												
Н			23a. Part . Enter the disease, or complications that caused the death. Do not e prock, or heart failure. List only one cause on each line.	S160 (S1 S1 S	or respiratory arrest,	Approximate Interval Between Onset and Death								
Alle.	Phy i i Medical		Immediate Cause (Final disease or condition resulting in death) a. UNOVAL AVIEW DISCUSE The to (or, is a consequence of):											
	Examiner		Dabetes W	Dabetes mellitus										
	n t	iner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying	andre Pelano	and dita	0.00.2								
	ecuter and al-trans	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of):	nictive Pulmon	ary vise	arc								
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3876	rtificat ling ph	ப வ ப	IF FEMALE:		Arian I									
P.O. Box 687	attend I for us	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 4 ☐ Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year								
О. В	the de by the tached	hysi	g Unknown	,, ,,										
s, P.(requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	by	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		use contribute to the cause of death? No 3 \(\text{Probably} \) Probably 4 \(\text{Unknown} \)								
ord	v requi	Completed			24a. Was an	24b. Were autopsy findings available								
Rec	The lay ate hay page 2	Som			autopsy performed? 1 ☐ Yes 2 ☑ N	prior to completion of cause of death? 1 Yes 2 No								
ital	sician: The certificate irector, pag	Be	25. Was case referred to medical examiner? 1	26. Place of Death (Chec										
of <	y Physer this eral di	e: 10	27. Manner of Death 28a. Date of injury 28b. Time	of 28c. Injury at	ome 5 Residence 6 28d. Describe how injur									
ono	ttending death. :tor: Afte / the fur	ficat	1 M Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	work? M 1 ☐ Yes 2 ☐ No										
Division of Vital Records,	I or Attending Phys after death. Director: After this d in by the funeral d	Certificate:	4 Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Street an City or Town, State	nd Number or Rural Route Number, e)								
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or inv	estigation, in my opinion, death occurred a	at the time, date and place	e, and due to the cause(s) and manner stated.								
	To the within 2 To the comple	Ň	only one) 3 Certifying Nurse Practitioner: To the best of my knowleds 29b. Signature and title of certifier	ge, death occurred at the time, date and p 29c. License number	1	e(s) and manner as stated. ate signed (Month, Day, Year)								
			· Esch MClotulis	m0067929	Nove	mber 24 202								
	5W		30. Name and address of person who completed cause of death (Item 23a) (Type III) FIFNO COSTON 8.118 COOD	Luck Road Lan	han M.D.	20706								
þ	Stat Registra	te 31. Date filed (Month, Day, Year) 7 2012 32. Fegistrar's Signature												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar 40647 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Nevember Benjamin E. Brew 10850A Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Prince George's Doctors Hospital Lanham . Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Davs Hours Country) 485-58-0955 Director 1 X XM 2 ... F 72 Yrs. Apr.13,1940 Ghana Usual Residence of Decedent 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits Director PA Philadelphia Philadelphia 1 X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2607 Welsh Road USA Apt. L105 19114 Brew, Benjamin Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian. Black, White, etc. þ 1 Never Married 2XXMarried ☐ Yes 2 **X X**No Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: Black If Yes. Give Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) IT Tech Computer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Benjamin E. Brew Elizabeth Odun 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 Benchley Place, 9H, Bronx, NY 10475 Mary Brew / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XXCremation 3 Removal from State Metro Crematory Nov.24,2012 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fureral Ser 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy, Bowie, MD 20715 23a. Part 1. Enter the disease, or complicat hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one ca Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Litter Underlying Cause (Disease or injury Due to (or as a consequence of): tran that initiated events resulting in death) Last Due to (or as a consequence of): physician a s the burial-Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? the g Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Pulmonza 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy death? perform 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 FR/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated neck 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

36 State nature and title of certifier

and address of person who completed cause of death (Item 23a) (Type, Print)

ndar

MD

Registrar's Signature

Registrar

DHMH 17 Rev 06-2011

MDD 72429

29d. Date signed (Month, Day, Year)

Good hack Rd. Lankam, MD. 20106

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Old WBer 20:18 pm Florence Elizabeth Baumgarten Medical 4a. Facility Name (if not institution, give street and number) Examiner Town, or Location of Death Baltimore **Funeral** Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) Months Min Director 579-30-4003 1 □ M 2 💢 F 86 July 07,1926 Washington DC er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore Baltimore 1 Yes 2 - No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1010 Leeds Ave 21229 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married ξ Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 □ Divorced specialhite 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Megines. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edwin Richard Prather <u>Clara</u> Day 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary M. Baumgarten/Son 1010 Leeds Ave.Baltimore, Maryland 21229 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lakemont Memorial 11/26/2012 Davidsonville, MD Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Atherosclerotic disease or condition resulting in death) Cardiovascular Medical unlnown Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of: eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month 5 Other (specify) Month 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed?

Yes 2 No 1 🗌 Yes or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 1 Inpatient 2 PER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Magner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 🗌 Yes 2 🗌 No 5 Pending 2 Accident Investigation 6 Could not be To the Hospital or Att within 24 hours after do To the Funeral Direct Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occur 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 00058141 NOVEMBER 20, emo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wendie Williams Baltimore Cato Avenue 31. Date filed (Month, Day, Year, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-08766 State of Maryland / Department of Health and Mental Hygiene 2012 40649 Crystal Dean Benton 1- For State WEND#1 per ME Registrar 11/28/2012 aaco health dept. Certificate of Death Reg. No 2. Date of Death 3. Time of Death Decedent's Name (First, Middle,Last) Physician/ 1345 hrs November 18, 2012 Medical Examiner Crystal Benton Jean 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Glen Burnie Anne Arundel Marley Neck Blvd and Freeman Shores Rd If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Maryland Months Davs Hours Director 12/10/1993 212-41-6144 1 M 2 X F Yrs Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 'n 10b. County 1 Yes 2 X No 28a-f show Maryland Anne Arundel Laurel i. Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

Tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medi-al Examiner must be notified at once. rector 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U. S. A. 20724 3419 Sudlersville South 14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married Yes White 1 Yes 2 X No specify: 3 Widowed Divorced If Yes. Give Year Specify: Š 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 Automotive Cashier 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Annette Jean Clark Alan Benton David 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 3419 Sudlersville South, Laurel, Maryland 20724 David Alan Benton/Father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 11/26/2012 Waldorf, Maryland **Huntt Crematory** 4 Donation 5 Other Specify. 22. Name and Address of Facility Fleck Funeral Home permit. 21. Signature of Funeral Service Licensee 100 7601 Sandy Spring Road, Laurel, MD 20707 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line **'Medical** Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, ner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed Physician/Medical AMENDED attending physician or use as the burial UNPENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year 1 Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown for 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown ficate has been si, page 2 should b 24b. Were autopsy findings available 24a. Was ar autopsy prior to completion of cause of performed? Yes 2 ✓ No death? 2 No 1 Yes After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 DOA 1 🗸 Yes 2 No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of Injury 27. Manner of Death Certification Subject passenger in auto auto collision Nov 18, 2012 1 Natural 1336 hrs 1 Yes 2 ✔ No Director: d in by the f Pending within 24 hours after death.

To the Funeral Director: 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) Marley Neck Blvd and Freeman Shores Rd, Glen Burnie, determined (Specify) Major Road / Highway Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) November 19, 2012 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Melissa Brassell, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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г	Physicia	n/	Registrar 1. Decedent's Name (First, Middle, Last))eatii	2. Date of Dear	th	3. Time of Death
وشطر	Medic	al	Margaret 4a. Facility Name (if not institution, give street		hheist		Location of Death	Manth/21	4c. County of De	11:00 A M
200	Examin	er	9301 Rosaryville	Road		Upper	Mar1boro			e George's
*	Funeral Director		5. Social Security Number	7. Age (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 11/10/1		Birthplace (State or Foreign Country) ashington, DC
	yland -f shov ed at	ctor	10a. State 10b. County		, Town or Loc					10d. Inside City Limits
	the Mai or 28a e notifi	Director	Maryland Prince Geo:	rge's U	pper m	arlboro 10f. Zip Code			10g. Citizen of What C	1 ☐ Yes 2 XX No
	h with ns 23a nust b	Funeral	9301 Rosaryville R	oad		20772	2		USA	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fu	1 Never Married 2 Married 1	Vas Decedent Ever in U.S Armed Forces? ☐ Yes 2X No f Yes, Give Year or Dates.	If	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 ★No	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	nerican Indian, ite, etc. White
15-0	72 hou n "natu Aedical		15. Decedent's Educatio (Specify only highest grade con	mpleted)	(Give A	ent's Usual Occupa ind of work done a NOT use retired)	ation Juring most of work	ing	16b. Kind of Busines	s/Industry
212	within ygiene.	a)	12	College (1-4 or 5+)		erior Dec	corator		Retail	
land	be filed ental H rked ot ic even	To B	17. Father's Name (First, Middle, Last) Frank Calvin De	oyle			18. Mother's Name Henriet	· ·	Maiden Surname) Lttle	
Mary	should and M is mar	1	19a. Informant's Name/Relationship (Type, Pri		L	•			City or Town, State, 2	
ē, N	and 2 Health tem 27 other to		Carl Buchheister / E. 20a. Method of Disposition	20b. PI		Hardesty sition (Name of	T		Maryland 20c. Location - City of	20689 or Town, State
imo	Page 1 ment of ant: If it ury or o		1 X X Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other <i>(Specify)</i>	oval from State St.	Barna		Čem. 12/1	/2012	Temple Hi	11s, MD
Balt	permit. Depart Import any inj	1	21. Signature of Juneral Service Licensee		6	Name and Addres	ss of Facility Geo Hill Rd.	rge P. k Oxon Hi	Calas Fune 11, Maryl	ral Home PA and 20745
			23a. Partid. Enter the disease, or complication shock, or heart failure. List only one cause Immediate Cause (Final							Approximate Interval Between Onset and Death
Bir.	Medical	5 1	disease or condition resulting in death)	CHRONIC R		AILURE				Oriosi una Bouri
A STATE OF	Examiner	er	Sequentially list conditions, b. —	DIABETES I		US, INSUI	LIN DEPEN	DENT		5 years
	nted d ansit	amin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c. —	HYPERTENS:						5 years
0	ate be executed ohysician and the burial-transit	dical Examiner	resulting in death) Last	Due to (or as a consequent ATHEROSCL)			5 years			
98760	rtificate ing phy e as the		IF FEMALE:							
. Box 687	he death certificat y the attending ph iched for use as th	Physician/Me	in the past 12 months?	yes, outcome of pregnan Live Birth 2 Fetal Pregnant at time of de Unknown	death 3	Ectopic pregnance Other (specify)	у		23d. Date of d Month	elivery Day Year
ls, P.O	requires that the de been signed by the s should be detached	by	Part II. Other significant conditions contribut	ting to death but not resu	ılting in the uı	nderlying cause giv	en in Part I.			to the cause of death? Probably 4 🗆 Unknown
Records, P.O.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Completed						24a. Was ai autops perform 1 \sum Yes	y prior to ned? death?	utopsy findings available completion of cause of es 2 \(\sum \) No
/ita	rsician: s certific	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospita	tal: 1 🗌 Inpatient 2 🗆 E		LOthe	ace of Death (Checker:		nce 6 🗆 Other (Spe	noife)
Division of Vital	or Attending Physician: The law after death. Director: After this certificate has d in by the funeral director, page 2	Certificate: T	1 X Natural 5 Pending 2 Accident Investigation		28b. Time of injury	28c. Injury work	at		w injury occurred	eny)
ivisi	of or Att. Directo		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	Be. Place of Injury - At hon building, etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (Str City or Town	reet and Number or R , State)	ural Route Number,
	To the Hospital or / within 24 hours after To the Funeral Dire completely filled in L	Medical	29a. Certifier (Check 2 Medical Examiner: Or only one) 3 Certifying Nurse Prac	n the basis of examination	and/or investi	gation, in my opinio	n, death occurred at	the time, date and	d place, and due to the	cause(s) and manner stated.
	To the withing the complete co	_	001 01 1 1111 0 110	npiler M		29c. License D 0420	number	2	ovember 20	th, Day, Year)
	And Services		30. Name and address of person who complete	ted Jause of death (Item	23a) (Type, Pi		ノ ー ナフ	1	TO VEHIDEL Z	0, 2012
	, ,		Alain Champaloux MD 31. Date filed (Month, Day, Year)	14314 01d	Mar1b		Upper Ma	rlboro,	MD 20772	
State 31. Date filed (Worth, Day, Year) Registrar NOV 2 8 2012 32. Registrar's Signature										

		For State Registrar	State of M	laryland	d / Depa <i>Cer</i>	artment of I tificate of I	Health : Death	and Mental Hy	/giene Reg. No		40651	
Physici		1. Decedent's Name (First, Middle, Last) Joan Norris	Brannock					2. Date of D Month Novem		19 2012	3. Time of Death 10:10 a M	
Medi Exami		4a. Facility Name (if not institution, give st Mallard Bay Ca	,	r		4b. City, Town, or Location of Death Cambridge			40	c. County of Deat		
Funeral Director		5. Social Security Number 6. Sex 188–28–6487			st birthday) Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date Months Days Hours Min. Ma y Ma y			ay, Year)	Coi	thplace (State or Foreign untry)	
yland f show ed at	tor	Usual Residence of Decedent 10a. State 10b. County MD Dorchest		10c. City,	, Town or Loc		4		,		10d. Inside City Limits	
the Mar or 28a-	I Director	10e. Street and Number				Cambri 10f. Zip Code			10g. Ci	itizen of What Co	1 Yes 2 □ No Puntry?	
eth with ems 23a r must k	Funeral	520 Glenburn Av	renue	Ever in U.S.	. 13. V		21613 Hispanic Ori	gin? (Specify Yes or No	- 1	USA 14. Race - American Indian,		
Filed within 72 hours after death with the Maryland tal Hyglene. Ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 Never Married 2 Married 3 X Widowed 4 Divorced	Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates.	No	11		an, Mexicar	i, Puerto Rican, etc.)	Black, White, etc. Specify: White		e, etc.	
hin 72 houne.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		5+)	(Give k	ent's Usual Occup ind of work done O NOT use retired) line wor	during mos	t of working	16b. k	Kind of Business/ $electi$		
VICT YIGHIO ZIZIS 2 should be filed within 72 h and Mental Hygiene. 77 is marked other than " traumatic event, the Mec	To Be C	17. Father's Name (First, Middle, Last)				TIME WOI	18. Moth	er's Name (First, Middle			Olites	
ite, Infallyld 1 and 2 should be if Health and Men item 27 is marke other traumatic	-	Albert Norris 19a. Informant's Name/Relationship (Typ)	e, Print)		19b. Mailin	g Address (Street	1	Violet Biki er or Rural Route Numb	r Town, State, Zip	Code)		
n 2		Glenn Brannock 20a. Method of Disposition	so	_		ocean Gat	eway,	East New		et, MD	21631	
Dallillor Dermit. Page 1 Department of mportant: If it any injury or o		1 👿 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	lemoval from State	_ ce	emetery, crem cheste	er Mem. F	ark	11/23/12	C	ambridge	e, MD	
partitioned permit. Page 1 at Department of H Important: If itel any injury or othone.		21. Signature of Funeral Service Licensee	9		22	Name and Addre	ss of Facilit	Thomas Fu , Cambridg	nera e, M	1 Home H D 21613	P.A.	
Ph_si_ian Medical		23a. Part 1. Enter the disease, or complishock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cause on each line	e.			1120-1	cardiac or respiratory a			Approximate Interval Between Onset and Death	
Examiner		Sequentially list conditions, by if any, leading to immediate	. deme	nti	a						5 years	
ate be executed physician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	. Due to (or as									
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transic.	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	Bc. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal	death 3	Ectopic pregnand Other (specify)	су		.,	23d. Date of del Month	ivery Day Year	
uires that the signed by uld be deta		Part II. Other significant conditions con	tributing to death b	out not resu	ılting in the uı	nderlying cause gi	ven in Part				the cause of death?	
The law required the has been signated as a should be	Completed by							perf	an opsy ormed? 2 X N	prior to death?	topsy findings available completion of cause of	
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ding Phy th. After this funeral o	cate: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of inju (Month, Da	iry 2	ER/Outpatien 28b, Time of injury	28c. Injur work	y at	28d. Describe			ny)	
I or Atten after dea Director: d in by the	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc		ne, farm, stre						al Route Number,	
e Hospita n 24 hours le Funeral	Medical	29a. Certifier 1 Certifying Physic (Check 2 Medical Examine only one) 3 Certifying Nurse	er: On the basis of e	my knowle examination e best of my	edge, death o and/or investi y knowledge,	ccurred at the time gation, in my opinion death occurred at t	e, date and on, death oc the time, dat	place, and due to the c curred at the time, date te and place, and due to	ause(s) a and place the cause	and manner as sta e, and due to the c e(s) and manner a	ated. cause(s) and manner stated s stated.	
To th To th		29b. Signature and little of certifier	n de			29c. License	e number 5 9 A	73	29d. Da	ate signed (Month	n, Day, Year)	
3			npleted cause of d	leath (Item 2	23a) (Type, Pi	nble.	Can	place, and due to the concurred at the time, date the tendent tendent to the concurred at the time, date to the concurred to	40)		
Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	ar's Signatu	ure	ack						

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 | 2 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 16 Physician/ 2012 17:52 P™ Bradley Kenneth Bradford Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Cambridge Dorchester Dorchester General Hospital If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) av 28, 1931 Min. 1 ₹ M 2 □ F Maryland 81 Yrs. May_ Director 214-28-8339 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 X No Church Creek MD Dorchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21622 USA 2796 Lakesville Crapo Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces þ 1 Never Married 2 X Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes. Give White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Meany injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Field Superintendent Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Olivia Wroten Alvin Kenneth Bradford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2796 Lakesville Crapo Road, Church Creek, MD 21622 Peggy J. Bradford wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 11/21/12 Cambridge, Maryland Dorchester Mem. Park 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home, P.A. 700 Locust St., Cambridge, MD 21613 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Non small cell ling Courses Physiciany Metastanz disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 lores 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 W Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 ☐ No ဂ္ 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: after death.

Director: After 1 1 Natural 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral D Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

DHMH 17 Rev 7/2009

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THANWY

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

57

29c. License numbe

YRN

		,	State of Maryland / Department of Health and N 1-State Registrar amend 22 per hosp. g934 12/Jerli i alshof Death	/lental Hy	2012	40653
r	Physicia	n/	1. Decedent's Name (First, Middle, Last)	2. Date of De	Day Year	3. Time of Death
	Medic Examin	al	tden Gaia Coleman 4a. Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death	10	04 20/3 4c/County of Death	08:10AM
بعائار	Examili	ei	Prince George's Hospital Center Cheverly		1 / /	reorges
· **	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Under 1 Year Wonths Days Hours Min. Yrs.	8. Date of Bir (Month, Da		place (State or Foreign htry)
le .		L	Usual Residence of Decedent 1	10-00		ryland
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. The shadth and Mental Hygiene. The show marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ecto	MD Prince George's Adelphi			10d. Inside City Limits 1 Yes 2 □ No
	h the N sa or 28 be no	al Dir	10e. Street and Number / 10f. Zip Code		10g. Citizen of What Cou	ntry?
	ems 2; r must	Funeral Director	8909 Tonbridge Terrace 3 0 783 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	14. Race - Americ	can Indian
36	after de I", or it camine	by	Armed Forces? If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	
00-10	thin 72 hours aftune. Ine. Ithan "natural", Ine Medical Exar	letec	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Business/Ir	ack
21215-0036	thin 72 ane. than " he Mec	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) NONE College (1-4 or 5+) NONE College (1-4 or 5+) NONE College (1-4 or 5+)	ng	None-I	-of-at
	filed wi al Hygie d other vent, t	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle,		211(667)1
Maryland	12 should be file lith and Mental I 27 is marked o r traumatic eve	٦ و	Marcellus Dewayne, Coleman Krister, 19a. Informant's Name/Relationship (Type, Print) mother 19b. Mailing Address (Street and Number or Rura		cole Chal	
, Ma	nd 2 sho salth an n 27 is er trau		19a. Informant's Name/Relationship (Type, Print) Mother 19b. Mailing Address (Street and Number or Rura Kristen Nicole Chalmers 8909 Tonbridge	. ,		
Baltimore,			20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Demoyal from State 2 Cremation 3 Cremati	Date	20c. Location - City or To	own, State
altin	in in in		2½. Signature 1 Furnifical Service 1/2 ensee 22. Name and Address of Facility	10/2012	6.50	
m	Dep Imp any onc	12	Prince George's Hos			
يغدر	Physician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o shock, or heart failure. List prily one cause op each line. Immediate Cause (Final			Approximate Interval Between Onset and Death
أمعه	Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. ARDIO PULLIONAL AU Due to (or as a consequence of): Sequentially list conditions, b. TET AL LIUMSTO	,,,,	,,,,	
i.		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	R-O		
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
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6876	artificate ding physe as th	/Med	IF FEMALE: 220 If you guitagraph of programmy			
Box	law requires that the death certifica has been signed by the attending pl e 2 should be detached for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of deliv Month	ery Day Year
o.	at the c d by the detache		9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e Did to	obacco use contribute to the	ne cause of death?
JS, P.	uires th n signe uld be o	ed by		1 🗆 1	\d	bably 4 🗆 Unknown
Records,	law req	Completed		24a. Was autop	osy prior to co	psy findings available mpletion of cause of
E Re	The ate h		25. Was case referred to medical 26. Place of Death (Check		rmed? death? 2 No 1 Yes	2 No
Vıta	nysician: nis certific I director,	To Be	examiner? 1 Yes 2 No Hospital: No Hospital: A Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hor		dence 6 Other (Specify)
n ot	ding Pł h. After tł funera		1 X Natural 5 Pending (Month, Day, Year) Injury work?	28d. Describe h	ow injury occurred	
Division of Vital	r Atten ter deal rector: by the	Certificate	3 Suicide 6 Could not be	28f. Location (S City or Tow	Street and Number or Rural	Route Number,
á	pital or ours aft eral Dir filled ir		29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an			nd .
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at only one) 3 Pertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place.	the time, date a	nd place, and due to the car	use(s) and manner stated.
	N With		29b. Signature at drifte of certifier 29c. License number 3		29d. Date signed (Month, I	Day (Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3. Date filed (Month, Day, Year) 3. Registrar's Signature	TOP 0	10AZ 0	102
	Stat	е	31. Date filed (Month, Day, Year) 32 Registrar's Signature	20	20	7,52
	Registra	r	MEC I 4 COLC LAND D. Man			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ 11:25A^M OLIVE ELIZABETH CARR 2012 Medical NOV 4b. City, Town, or Location of Death Easton 4a. Facility Name (if not institution, give street and number) 4c. County of Death Talbot Examiner Genesis HealthCare-The Pines 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 💢 F Months Days Hours Min 02712/1934 WASHINGTON, DC 577-46-1588 78 Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director MD **TALBOT** ST. MICHAELS 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 206 CARPENTER ST. BOX #1141 21663 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian was Decedent Ever Armed Forces 1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 X Never Married 2 Married þ 1 ☐ Yes 2 X No Specify: WHITE Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) BANKING CLERK Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ OLIVE PAULINE HUGHES WILLIAM PETER CARR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2101 S.MERIDIAN RD. #117 APACHE JUNCTION, AZ 85120 SUSAN L. HOULE / NIECE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 12/3/2012 WASHINGTON, DC **OLIVET CEMETERY** PENEROWS GOTHELFRENBEIN & NEWNAM FUNERAL HOME, P.A. 21. Signat of Fund Lervice Licensee 200 S. HARRISON ST. EASTON, MD 21601 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on the order of the death. Interval Between failure to then Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 death? 1 ☐ Yes 2 ☐ No Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital: é 1 ☐ Yes 2 🗙 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: work? 1 Natural injury 5 Pending 1 🗌 Yes 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗀 Homicide determined

Examiner the burial-transit P.O. Box 68760 attending phase as the signed by the a Division of Vital Records, page 2 should Hospital or Attending Physician: 24 hours after death. Funeral Director After this certificated filled in by the funeral director,

Funeral

Director

28a-f show

ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at

within 72 hours after

should be filed within 72 l and Mental Hygiene. 7 is marked other than "n

permit. Page 1 and 2 should be.
Department of Health and Mental Important: If item 27 is meany injury or other

Ph_sician/

Medical

OLIVE Carr Baltimore, Maryland 21215-0036

State

Medical

29a. Certifier (Check

only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of leath (Item 23a) (Type, Print)

1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

utchness in Easton MD 2160

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State of Maryland / Department of Health and Mental Hygien & U State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Alvin E. Coleman, Jr. ^D25, November 2012 P M 3:46 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 215-12-8390 Year 95 Director 1 X M 2 □ F Nov. 12, 1917 Maryland Usual Residence of De 28a-f shov 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland Anne Arundel Annapolis 1 Yes 2 XXV 10 Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 712 Pinewood Drive 23a 21401 U.S.A. Funeral "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?

1 XX es 2 No
If Yes, Give Black, White, etc þ 1 Never Married 2 XXMarried Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify Specify. White Completed 3 Widowed 4 Divorced Year or Dates. WW Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 72 Il Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) the Computers U.S. Government 4 Be . Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I Alvin E. Coleman Myrtle Gladden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Coleman/wife 712 Pinewood Drive Annapolis, Maryland 21401 1 and 2 s of Health item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 permit. Page 1 Department of Important: If it any injury or o jo 1XXBurial 2 Cremation 3 Removal from State Hillcrest Mem. Gardens 11/29/2012 Annapolis, Maryland 4 Donation 5 Other (Specify) Sign Illian Ineral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home old 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician Pneumonia disease or condition resulting in death) 3 days Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury and to fix we're nonequence off law requires that the death certificate be executed and -trans that initiated events resulting in death) Last Due to (or as a consequence of): ician al burial-1 Physician/Medical e attending physic d for use as the b Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death the 9 Unknown 9 I Inknown signed by t d be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4XXUnknown Completed been . Were autopsy findings available prior to completion of cause of death? 24a. Was an has autons performed? page certificate 1 Yes 2 No 25. Was case referred to medical Hospital or Attending Physician: director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 ☐ Yes 2 🗶 No 1 X Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After (Month, Day, Year) injury 1 XX Natural 5 Pending 1 Yes 2 No n 24 hours after death.

e Funeral Director: A pletely filled in by the fu M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2

To the I

complete 3 🗆 only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number H0070482 Nov. 25, 2012 all RO. WY person who completed cause of death (Item 23a) (Type, Print) Keith Goulet 2001 Medical Parkway Annapolis, MD W

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year,

NOV 28

32. Registrar's Signature

21401

Genesis La Plata Center La Plata Cha Social Security Number 5. Social Security Number 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) Months Days Hours Min. 0.5 / 13 / 19 36 Usual Residence of Decedent 10a. State 10b. County MD Charles Hughesville	arles
4a. Facility Name (if not institution, give street and number) 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. Coulons 4c. Coulons 4d. Coul	ounty of Death arles 9. Birtholace State or Foreign
Funeral Director 5. Social Security Number 5. 7 - 5 0 - 6 9 6 3 1 1 2 M 2 1 F 7. Age (In yrs. last birthday) 7 6 Yrs. 1 Months Days Hours Min. 0.5 / 1.3 / 1.9 3 6	9. Birthplace (State or Foreign
103/13/1936	_ Country)
MD Charles Hughesville	
2 R C 10 10e. Street and Number 10f. Zin Code 10g. Citizon	10d. Inside City Limits 1 ☐ Yes 2 ☒ No
₹ 8	n of What Country?
98	Race - American Indian, Black, White, etc. ecify: White
Specify only highest grade completed) Specify only highest grade completed) College (1-4 or 5+) Pile Driver Pile Driver	of Business Industry
Spect No. Specify: Specify and property of the property of	Drivers Local , Wash. D.C.
To set the set of the	,
The state of Diange 17. Father's Name (First, Middle, Last) Lester Diange 18. Mother's Name (First, Middle, Maiden Surm. Henrietta Offsham 19 18. Mother's Name (First, Middle, Maiden Surm. Henrietta Offsham 19 18. Mother's Name (First, Middle, Maiden Surm. Henrietta Offsham 19 19a. Informant's Name/Relationship (Type, Print) Victoria Diange/Spouse 19a. Informant's Name/Relationship (Type, Print) Victoria Diange/Spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Tow. 14600 Box Elder Ct., Hughesvi. 19 20a. Method of Disposition 1	wn, State, Zip Code)
20a. Method of Disposition 1 Date 20c. Location 1 Date 20c. Location 20b. Place of Disposition (Name of cemetery, crematory or other place)	tion - City or Town, State
4 Donation 5 Other (Specify) Metro Crematory 12/05/12 Alexa Alex	andria, VA al Svc., ÞA
M01517 5635 Washington Ave., La P1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,	lata, MD 20646
shook, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition For which the think	Interval Between Onset and Death
Medical resulting in death) Due to (or as a consequence of): Due to (or as a consequence of):	
in any, loading to immodiate Due to (or as a consequence of):	
per part of the control of the contr	
froate be expriscion as the burning	
in the post 12 months?	d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	contribute to the cause of death?
The law requires 2/20N 24a. Was an autopsy performed? 1 \(\text{Yes} \) 2/20N 24a. Was an autopsy performed? 1 \(\text{Yes} \) 2/20N 24a. Was an 2/20N 24b. Was an 2/20N 24b. Was an 2/20N 24b. Was an 2/20N 24c. W	24b. Were autopsy findings available
autopsy performed? 1	prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical examiner? 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Inpatient 2 ER/Outpatient 3 DOA 1 Inpatient 2 ER/Outpatient 3 DOA	
Composition	
27. Manner of Death 1 Natural 29 Autural 29 Autural 20 Accident 3 Suicide 4 Homicide 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? 1 Yes 2 No 28d. Describe how injury occ work? 1 Yes 2 No 28d. Describe how injury occ work?	umber or Rural Route Number,
Some serious process of the process	d due to the cause(s) and manner stated.
only one) 3 L Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Date signature and title of certifier	igned (Month, Day, Year)
HM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6934 Philoson Blvd. She B Glern Burnic in D 21061	- C-
State Registrar 31. Date filed (Month, Day, Year) 32. Registrar Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40657 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ 11:31AM DAVIS 2012 DECEMBER 4 DORIS JANE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 8. Date of Birth (Month, Day, Year) 4, 1934 9. Birthplace (State or Foreign Country) Mary Land If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 218-30-9290 78 Director 1 □ M 2 🛈 F Usual Residence of Decedent 10d. Inside City Limits 27 is marked other then "neturel", or items 23e or 28a-f shor treumetic event, the Medical Evandrant must be netitled at 10c. City, Town or Location Director Frederick 1 🗌 Yes 2 🖺 No Maryland Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 5719 Shookstown Road 21702 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo
If Yes, Give Black, White, etc. \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed I 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 end 2 should be filed within 72 Department of Health end Mental Hygiene. Importent: If Item 27 Is marked other then 'any Injury or other treumetic event, the Ma Elementary/Secondary (0-12) College (1-4 or 5+) Manufacturing Assembly Line Be 18. Mother's Name (First, Middle, Maiden Sumarne) 17. Father's Name (First, Middle, Last) Pauline Blank ပ္ Edward Olin Veirtz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zin Code) 5719 Skookstown Road, Frederick, MD 21702 Charles E. Davis, Husband 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Rocky Springs Cemetery Dec. 8, 2012 1 Burial 2 Cremation 3 Removal from State Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice ²²Klareney and Basford PA Funeral Home 106 East Church St., Frederick, MD M00255 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician/ ementia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examir anding physicien and use es the burial-transit thet the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 ettending p IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Petal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospitel or Attending Physicien: The law requires th within 24 hours after death.

To the Funerel Director: After this certificate has been signe completely filed in by the funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed?

Yes 2 No. 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) **Division of Vital** Be Hospital 2 No Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 2 28a. Date of injury (Month, Day, Year, Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation is multiplied to the cause (s) and manner as stated. Medical 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Registrar

State

31. Date filed (Month, Day, Year)

DEC 1 4 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40658 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^M11/21/2012 10:15 AM JOYCE WILSON DAFFIN Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death **EASTON** TALBOT HOSPICE HOUSE TALBOT Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) Director 239-48-6433 1 □ M 2 🗱 F 78 AUG. 16, 1934 NORTH CAROLINA ed other then "netural", or Items 23a or 28e-f shovevent, the Medical Evanimer must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No **TALBOT** MD **EASTON** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 9676 LEEDS LANDING CIRCLE 21601 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 ☐ Yes 2 🔀 No 1 Never Married 2 X Married hours efter 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates WHITE 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry filed within 72 tal Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be filed Department of Heelth end Mental H Importent: If Item 27 Is marked of eny Injury or other traumatic even 2008. မှ WILLIAM EARL WILSON MARY GRIMMER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANK E. DAFFIN, JR., HUSBAND 9676 LEEDS LANDING CIRCLE, EASTON, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) KENLY CEMETERY 11/29/2012 KENLY, NORTH CAROLINA 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, MERCERON HARRISON STREET, EASTON, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death) Onset and Death CANCER LUNG Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events ettending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 death? To the Hospitel or Attending Physician: I within 24 hours after death.

To the Funerel Director: After this certifics completely filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) Residence 6 \(\text{TALBOT}_{fy} \) HOSPICE **1**0 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death

Natural

Accident

Suicide

Homicide Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title o 29c. License number 29d. Date signed (Month, Day, Year) D3988 11-21-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DRUDAVID SMITH, 8221 TEA 8221 TEAL DRIVE, EASTON, MD 21401 RS 6

DHMH 17 Rev 06-2011

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Division of Vital Records,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 40659 State of Maryland / Department of Health and Mental Hygien 7 1 2 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11724/2012 DiMartino Sr. 10:40A M Anthony Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Southern Maryland Hospital Clinton Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** Hours 577-32-7660 85 **Director** 1 🛛 M 2 🗆 F 07/08/1927 Washington, DC Usual Residence of Decede ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Prince George's 1 Yes 2 XXVo Marvland Forestville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 20747 3410 Pumphrey Drive USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 1. Marital Status Black, White, etc. à 1 Never Married 2 XXMarried 1 ☐ Yes 2 👿 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify 3 Widowed 4 Divorced Completed White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Federal Government Assistant Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Verzilli Giovanni DiMartino Adelina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Joyce DiMartino / Wife Pumphrey Drive Forestville, MD 3410 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State St. Mary's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 11/29/2012 Washington, DC Signatur Funeral Service Licens e 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Rd. Oxon Hill, Maryland 20745 It caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. 23a. Part 1. Enter the disease, o complications the shock, or heart failure. List only one cause of terval Between Onset and Death Immediate Cause (Final Phytician/ week PNEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** RENAL FAILURE 2 weeks Sequentially list conditions, Examine Due to lor as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician /Medical Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE nse Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No 9 Unknown 9 Unknown signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Diabetes Mellitus 1 Yes 2 X No 3 Probably 4 Unknown Completed Cellulitis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page ? perform certificate 1 Yes 2XXNo 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 X No 1 Yes 1XXInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) ၉ funeral 27. Manner of Death 28c. Injury at work?
1 Yes 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 X X latural 5 Pending s after death.

I Director: Affer in by the further 2 🗌 No Investigation 6 Could not be Accident Suicide רות היוח 24 hours. אי F**uneral Dir**e. ייע filled in by. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🕱 Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. mpletely thing Physician. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

The physician is a second of the cause (s) and manner stated.

The physician is a second of the cause (s) and manner stated.

The physician is a second of the cause (s) and manner as stated. To the P within 2, To the F complet 3 Cer 29d. Date signed (Month, Day, Year) 11/25/2012 29b. Signature and title of ce 29c. License number D 19633 4x30 Mpeted cause of death (Item 23a) (Type, Print) 7501 Surratts Rd. #201A Clinton, Maryland Patterson John 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

NOV 2 8 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 \(\begin{align*}
\text{ } \\ \text{ } \ \text{ } \\ 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month AM nne 2012 ne1.5 Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Jorchester laşt birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F (Month, Day, Months Days Hours Min. Director () Maryland Usual Residence of Decedent "natural", or items 23a or 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 WYes 2 □ No Cambridg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 161 Page 1 and 2 should be filed within 72 hours after death Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give 3 Widowed 4 Divorced Black Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Manufacto Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ rvilee Brannac 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ennels 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 251 STROCK CEMEtery 4 ☐ Donation 5 ☐ Other (Specify) ambridge 22. Name and Address of Indility
Henry Funeral
Sio Washington 21. Signature of Funeral Service Licensee HOME, any MD.21613 Str Cambrida Port 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ oronar. diseel disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** ertensio Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month certificate has been signed by the rector, page 2 should be detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 nknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d, Describe how injury occurred 1 Natural work?
1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatare and title of certifier 40120 Kamin el 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) rando n

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

5500 Anders

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 19, 2012 4:37 PM Emil Ettore Fagiolo Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign **Funeral** Months 220-54-1386 Director 1 🗙 M 2 🗆 F 63 7/14/1949 Maryland Usual Residence of Dec 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f sh notified Edgewater Anne Arundel Maryland 1 Yes 2 X No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? be USA 23a Funeral 21037 3673 8th Avenue must Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Armed Force Black, White, etc. ō δ 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: "natural", Completed Specify: 3 🗆 Widowed 4 🗆 Divorced White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 72 alth and Mental Hygiene. 127 is marked other than "I traumatic event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) Paving Contractor Self-Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Emil E. Fagiolo Sr. Dorothy Lorraine Clore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trau 3673 8th Avenue, Edgewater, MD 21037 Nancy Hall - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Hillcrest Mem. Garden's 11/26/2012 Annapolis, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Physicsus/ Onset and Death disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if you have in the sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Dav Pregnant at time of death Year 2 No 9 Unknown Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 1 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parkway Ste 210 Annapolis 2003 Medica urtis turr 31. Date filed (Month, Day, Year Registrar's Signature State Registrar

For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Malcolm | **Elmer** Goode, Sr. 8:30 P M 2012 November 28. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's St. Mary's Nursing Center Leonardtown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Funeral Months Hours (Month, Day, Year) Director 217-36-9875 1 🕱 M 2 🗆 F May 7, 1927 Maryland | Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 Yes 2 X No. Chaptico St. Mary's Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20621 23140 Pond Point Farm Lane TISA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian r than "natural", or iter the Medical Examiner Armed Forces Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) iit. Page 1 and 2 should be filed withi artment of Health and Mental Hygiens ortant: If item 27 is marked other th injury or other traumatic event, the Farming 12 **Farmer** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Dora Lyon Douglas Goode 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23120 Pond Point Farm Lane Chaptico, MD 20621 Malcolm E. Goode, Jr./ Son 20b. Place of Disposition (Name of cemetery, crematory or other place 20a, Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State 12/03/2012 Sacred Heart Bushwood, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A.
41590 Fenwick St., Leonardtown, MD 20650 9 ardener 23a. Pary I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physicson/ Acute renal orwire disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Dementia Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Failure to thrive Cause (Disease or injury use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 No Vital 25. Was case referred to medical funeral director, To Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 XV0 1 Inpatient 2 ER/Outpatient 3 DOA ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ot 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Division 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide determined within 24 hours a

To the Funeral C

completely filled To the Hospital Medical 29a. Certifier 1. 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0070900 12 gestinent 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6934 Another Blvd, Suite Bi Glen Burne, MD 10) Rme 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40663 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Marie Allana Grant 6:05PM 2012 Medical <u>November</u> 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 39002 Hollybank Drive Mary's Mechanicsville St. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Hours Director 186-34-3168 1 M 2X XE 70 03/04/1942 Uniontown, PA Usual Residence of Deced permit. Page 1 and 2 should be filad within 72 hours after death with the Maryland Dapartment of Haalth and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, the Madical Examiner must be notified at once. 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No St. Mary's Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 39002 Hollybank Drive 20659 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ANo Specify: White Specify. 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Office Manager U.S. Navy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Orville Gordon Ellen Salvato 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise O'Grady / Daughter 39002 Hollybank Drive, Mechanicsville, MD 20659 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State St. Mary's Piscataway Church Cemetery 12/05/2012 1 A Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Clinton, Maryland Signature of un of Service Licenses 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. M00817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Éxaminer Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the daath cartificata be executed within 24 hours after death.

To the Funeral Diractor: After this certificata has been signed by the attending physician and complately filled in by the funeral director, page 2 should be datached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 XNo Other: Certificate: To 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 D Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H00

State Registrar 30. Name and address of per

31. Date filed (Month, Day, Year)

Schmidt,

D.O.

32.

Jennifer

40900 Merchants Lane, Leonardtown, MD

20650

who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40664 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Greene John 0036 11 2012 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Maryland Med: a University of Baltimore (enter 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Min. (Month, Day, Year) 52-8437 Director 1 🛛 M 2 🗆 F Yrs. 66 MARYland 10b. County Page 1 end 2 should be filed within 72 hours after death with the Maryland ment of Heelth end Mental Hygiene. ent: If item 27 is marked other then "neture!", or items 23e or 28e-f sho Department of Heelth end Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23e or 28e-1 sho eny Injury or other treumetic event, the Mydical Examinar must be notified at 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Yes 2 I No hester 1 d 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? US A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces' Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 🗆 Widowed 4 🗆 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Never worked Never worked Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Ignaious 19a. Informant's Name/Relationship Type, Print) 19b. Mailing Address (Street and Number Rural Route Number, City or Town, State, Zip Code) Mable Greene Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State Bethel Cambridge, 4 ☐ Donation 5 ☐ Other (Specify) 12-01-2012 21. Signalur of Funeral Service Sicensee 22. Name and Address of Facility Bennie Smith Funeral Home 4 Race 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ leukenia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or rigury that initiated events Examine Due to (or as a consequence of): within 24 hours after death.

To the Funerei Director: After this certificate has been signed by the ettending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-trensit Hospital or Attending Physician: The lew requires that the deeth certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Was an autopsy
performed?

1 Yes 2 A No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 욘 1 € Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural injury 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gettiying Prijsscalar for the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 1699041699 29b. Signatu and title of certifier 29d. Date signed (Month, Day, Year) 11/22/2012 Harall 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rowan Hurrell 7.7 > Green

Registrar DHMH 17 Rev 06-2011

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31. Date filed (Month, Day, Year) NOV 2 8 2012

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32. Registrar's Signature

St Baltimore, Md 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40665 Reg. N2 0 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month November 25 2012 Physician/ Paul Delphey Gaither Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Funeral Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Director 578-38-3098 1 X M 2 D F 8/19/1925 Brunswick MD Usual Residence of Decedent filed within 72 hourstal Hygiene.
ed other than "natural", or items 23a or 28a-f show
ed other than "natural", or items 23a or 28a-f show
e ovent, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Frederick Brunswick 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 716 North Maple Ave. 21716 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black White etc. δ 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. Specify: 3 Widowed 4 Divorced Completed White Year or Dates. 1942 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Fred. Co. Schools Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 Is marked o ည Paul William Gaither Mame Ruth Barger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 716 North Maple Ave. Brunswick MD 21716 Cathy Barnes, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State any injury or 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hagerstown Crematory 11/29/2012 Hagerstown MD 21. Signature of Funeral Service libense 22. Name and Address of Facility Foret L Jalle John T Williams Funeral Home, Brunswick MD 21716 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death MITERY Physician/ ORO NATU/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner EMENTIA Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) The law requires that the death certificate be executed anding physician and use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day signed by the aid Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 No ☐ Yes 1 Tes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 1 🗌 Yes မ 1 Inpatient 2 KER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending 1 Yes 2 No Investigation filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D4795 11-27-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10-- 4 KAZMI MN SIY TOIL HOUSE AUF. FREDERICK.

Registrar DHMH 17 Rev 06-2011

1 9 State

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 23 2012 5:05A M Shirley Jean Gaddy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Frederick Frederick Memorial Hospital Frederick 5. Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min. (Month, Day, Year) **Director** 235-64-8883 1 □ M 2 🔀 F 71 10-06-41 Taplin, WVA Usual Residence of Deceden Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 XX Yes 2 ☐ No Washington D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20005 United States 1220 12th Street, N.W. #512 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. rmed Forces? Black, White, etc. Ś 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 A No Specify: Completed 3 Widowed 4 Divorced Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Teacher Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ Chester Arthur Shelton Willie Ruth Shelton Pippins permit, Page 1 and 2 should be Department of Health and Men Important: If item 27 Is marke any Injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William James Gaddy/husband 12th St., N.W. #512, Washington, D.C. 20005 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 😾 Burial 2 □ Cremation 3 🔀 Removal from State 4 □ Donation 5 □ Other (Specify) Glenwood Cemetery 11/29/12 Washington, D.C. 21. Signature of Funeral Service License 22. Name and Address of Facility McGuire Funeral Service 7400 Georgia Avenue, N.W., Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final CARDIO MYOPH THY Onset and Death AMYLOI Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of attending physician and I for use as the burial transit Exami Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death Year Day Yes 2 No 9 Unknown 9 Unknown ۾ ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe this certificate Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ည 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending within 24 hours after death.

To the Funeral Director: Al Completely filled in by the funeral Director. 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: So the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Murse Pactitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

ess of person who completed cause of death (Item 23a) (Type, Print)

TOLL HOUSE Hy,

			1 - State of Marylar Registrar	id / Depa <i>Cer</i>	artment of F tificate of L	Health and I Death	Mental Hy	giene Reg. No.	12 40667
		,	Decedent's Name (First, Middle, Last)				2. Date of Dea	ath	3. Time of Death
	Physicia Medic		RAJ KUMARI GROVER				Month NOVEMBE	R 25 2	2012 9:30 P M
and of	Examin	er	4a. Facility Name (if not institution, give street and number)			Location of Death	ר	4c. County	
and the			14364 BEAKER COURT 5. Social Security Number 6. Sex 7. Age (in yrs. i	ast hirthday)	BURTONS If Under 1 Year	VILLE I If Under 24 Hrs.	8. Date of Birt	MONTGO	
В	Funeral Director		219-64-9410 1 M 2 X F 67	Yrs.	Months Days	Hours Min.	(Month, Day		Birthplace (State or Foreign Country)
9			Usual Residence of Decedent				10/9/1	945	INDIA
	yland •f sho ed at	Director		y, Town or Loc					10d. Inside City Limits
	e Mar r 28a- notifi)ire	10e. Street and Number	TONSVII					1 ☐ Yes 2X No
	rith th		14364 BEAKER COURT		10f. Zip Code			10g. Citizen of W	
	ems r	Funeral	11. Marital Status 12. Was Decedent Ever in U.	S. 13. V	20866 Vas Decedent of Hi	ispanic Origin? (Sp		UNITED S	OTATES - American Indian,
9	ter de , or it	by F	1 ☐ Never Married 2 ☐ Married Armed Forces?	If	Yes, specify Cuba	n, Mexican, Puerto	o Rican, etc.)	Black	k, White, etc.
21215-0036	urs af tural" al Exa		3 X Widowed 4 □ Divorced If Yes, Give Year or Dates.	1	☐ Yes 2 🌠 No	Specify:		Specify:	ASIAN
15-	72 ho n "na"	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occup ind of work done o		king	16b. Kind of Bu	siness/Industry
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þ	filed valued to the second of	Be	17. Father's Name (First, Middle, Last)		ITOIIDI	18. Mother's Nar	ne (First, Middle,		
ylar	d be Menta arkec	ပ	SWAROOP LAL ARORA			ASHA CHO	OPRA		
Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	g Address (Street a	and Number or Rui	rai Route Number	, City or Town, St	ate, Zip Code)
	and 2 Health em 2; ther t		AVIV GROVER / SON 20a. Method of Disposition 20b. F		RIVER FA	LLS CT.,			
Baltimore,	age 1 ent of it: If it y or o		1 D Burial 2 V Cramation 2 D Bamaual from State	emeterv. crem	atory or other plac	e) ON 11/	Date		City or Town, State
ij	nit. P.		4 □ Donation 5 □ Other (Specify) 21. Signature of Fuperal Service Liceptee	ENTER	CREMATI Name and Addres	ss of Facility LAS			VILLE, MD Y FELLOWS,
ñ	permir Depar Impor any in		1 FRAM	HE	LFENBEIN	& NEWNA	AM CREMA	TION & F	UNERAL CARE
			23a. Part 1. Enter the disease of complications that caused the deat shock, or heart failure dist only one cause on each line.	h. Do not enter	r the mode of dying	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between
	Physician/		Immediate Cause (Final disease or condition	lized	debil	ity			Wong and beath
	Medical Examiner		resulting in death) Due to (or as a consequ			7			VOANS
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	execu an and rial-tra	Ex	that initiated events c. Due to (or as a consequence of the constant of the co	ience of):					
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	rtifica ling pl e as t	w	IF FEMALE:						
Box 687	eath certifica attending p	cian	23b. Was decedent pregnant in the past 12 months? 1	al death 3 🗌	Ectopic pregnanc Other (specify)	у		23d. Date Mon	e of delivery oth Day Year
m.	y the ched	by Physician/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 ☐ Unknown	leatii 5 🗆	Other (specify)				
P.O.	requires that the de been signed by the s should be detached	y Pi	Part II. Other significant conditions contributing to death but not res	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did to	bacco use contri	bute to the cause of death?
S,	quires en sign	ed k	hypertension				1 🗆 Y	es 2 No	3 ☐ Probably 4 ☐ Unknown
Records,	aw rec as bee 2 sho	Completed					24a. Was a	n 24b, W	/ere autopsy findings available rior to completion of cause of
Be	The Is	Com					perfor	med? de	eath?
ta	cian: ertific ector,	Be	25. Was case referred to medical examiner?			ace of Death (Chec	ck only one)		
Ę.	Physi this c	은	1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ 27. Manner of Death 28a. Date of injury	ER/Outpatient 28b. Time of		4 L Nursing H	ome 5 Resid		
Division of Vital	ding th. After fune	Certificate:	1 Natural 5 Pending 2 Accident Investigation (Month, Day, Year)	injury	28c. Injury work' M 1	rat ? Yes 2 □ No	28d. Describe ho	ow injury occurred	3
isio	Atten er dea ector: by the	Ţ	3 Suicide 6 Could not be 28e. Place of Injury - At ho			100 2 2 110			r or Rural Route Number,
<u>≥</u>	tal or rs afte al Din led in		building, etc. (Specify,	,			City or Town	n, State)	
	Hospi 4 hou Funer tely fil	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowl (Check 2 Medical Examiner: On the basis of examination	edge, death or	ccurred at the time	, date and place, a	and due to the ca	use(s) and manne	r as stated. to the cause(s) and manner stated.
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.	Me	only one) 3 Certifying Nuce Practitioner: To the best of m				lace, and due to th	e cause(s) and ma	anner as stated.
	F ≥ F 8		MY	1)	D3	845	7 1	11261	(Month, Day, Year)
	2		30. Name and address of person who completed cause of death (Item	23a) (Type, Pr	int)		7 9	11/24/	
	3		Nakul Coyal, MD/PA 3801 International i			20006			
	Stat	е	31. Date filed (Month, Day, Year) 7 2012 32. Registrar's Signat	ure 💪	An al a	rd zozoo			
	Registra		MUT ~ 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	a. 1	M. C. C.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40668 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death M Physician/ HIONG 2017 Medical 4a. Facility Name (if not institution give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death <u> Mandrin Hospice House</u> <u>Harwood</u> Anne Arunde1 If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last hirthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Hours Country) 186-32-7253 **Director** 71 1 M 2 X F Yrs 11/23/1941 Usual Residence of Dece PA r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director MD Anne Arundel Odenton 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8601 Roaming Ridge Way Apt 205 21113 USA death 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Armed Forces Black, White, etc. 1 ☐ Yes 2 🗓 No If Yes, Give ⋧ 1 Never Married 2 Ty Married Maryland 21215-0036 hours after 1 ☐ Yes 2 ☐ No Specify: Il Hygiene. other than "natural", 3 Widowed 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) within 72 Elementary/Secondary (0-12) College (1-4 or 5+) Executive Secretary Hospital Plan Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H 27 is marked of traumatic ever pe A1 0vera Sally Siddal permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic , <u>once.</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Guida/Spouse 8601 Roaming Ridge Way Apt 205 Odenton, MD 21113 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crematory Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/27/2012 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fune al Service Licensee 22. Name and Address of Facility 851 Annapolis Road Gambrills,MD 21054 Vat Hardesty Funeral Home P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Wise With disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial infector, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 4 Pregnant : 9 Unknown Pregnant at time of death Month 1 Yes 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 🗌 No ☐ Yes 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: [윤 1 🔲 Yes 2 No Other: 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie alun Name and address of person who completed can se of death (Item 23a) (Type, Print) CHALL 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 27 2012 Registrar

AACO Health Dept	_ For		e Type or Pr State of N					nd Mental H		-	40669		
Physician/ Medical		ne (First, Middle, L Mario Ga:			Cert	ificate of	Death	2. Date of E Month	Di	24 2012	3. Time of Death		
Examiner			ive street and number)			4b. City, Town, o	EN F	Surnie	40	C. County of Deat	ARWIDEL		
Funeral Director	5. Social Security I 194-14- Usual Residence	4949 of Decedent	Sex 7. A	ge (In yrs. Ia:	Yrs.	If Under 1 Year Months Days			Day, Year)	Co.	hplace (State or Foreign untry) PA		
death with the Maryland items 23a or 28a-f sho ner must be notified at Funeral Director	MD 10e. Street and Nu	Anne Ar	nnel rundel	1	Town or Local						10d. Inside City Limits 1 ☐ Yes 2 🛣 No		
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0036 urs after de tural", or it Examine ted by F	1 Never Mar		If Yes, Give Year or Dates.			Yes, specify Cub ☐ Yes 2 ☐XNo		? (Specify Yes or No uerto Rican, etc.)		Black, White			
21215-003 21215-003 within 72 hours aft giene. er than "natural", the Medical Exa	(Sp Elementary/Sec	15. Decedent's ecify only highest (condary (0-12)		5+)	(Give kii	nt's Usual Occup nd of work done NOT use retired,	during most of	working		Kind of Business/			
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	17. Father's Name	7. Father's Name (First, Middle, Last) Lawrence Gaia 18. Mother's Name (First, Middle, Maiden Surname) Adelia Dezebio											
e, Mary and 2 should Health and N em 27 is ma ther trauma	19a. Informant's Name/Relationship (Type, Print) Christine G Hopper (daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 609 Eliot Rd Pasadena, MD 21122								Code)				
Baltimore, Bernit. Page 1 and Bepartment of Her Moortant: If item my injury or othe	20a. Method of Disposition 1										e, MD		
Balti Permit. Departi Importi any inji	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home 851 Annapolis Rd Gambrills, MD 21054 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between												
executed an and Medical Examiner I Examiner	Immediate Cause disease or conditi resulting in death) Sequentially list or if any, leading to it cause. Enter Unde Cause (Disease or that initiated even resulting in death)	(Final on ditions, mmediate arlying injury ts	a. PHO Single to (or as Due to (or a) Due to	a conseque	ence of):	-		PAIL		C YSA	Interval Between Onset and Death		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 40670 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2:00 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Annapolis Anne Arundel Annapolitan 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Director 212-60-2357 1 □ M 2 🗓 F 80 11/06/1932 Japan tel Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lipiny or other traumatic event, the Medical Examiner must be notified and enty. 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Annapolis 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1211 Hilltop Dr. 21409 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ð 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed 3 X Widowed 4 Divorced Asian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4 or 5+) Retail Seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Tsunni Isikawa -Sada 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary A. Talbot (daughter) 3415 Moylan Dr. Bowie, MD 20715 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/25/2012 Atlantic Crematory Glen Burnie, MD 21. Signature of Funeral Septine Licensee 22. Name and Address of Facility Hardesty Funeral Home 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final PANCREATIC Sand Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien end completely filled in by the funeral director, page 2 should be detached for use es the burlat-transit ause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🛣 No
9 ☐ Unknown 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 \square Pending work? Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11-20-12 445 Defense Highway Annapolis, MD 21401 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAHID AZIZ M-D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 27 Registrar

Box 68760

Division of Vital Records,

		1 - For AMEND#8 per FM State of Maryland / Depar State of Maryland / Depar Registra 12/6/12 AACO HEALTH DEPT. CMH Certif	tment of Health and N ificate of Death	1ental Hygie	2012	40671			
Physici		1. Decedent's Name (First, Middle, Last) John E. Grooms	S	2. Date of Death		3. Time of Death 2:58 P M			
Medi Exami		4a. Facility Name (if not institution, give street and number) Civista Medical Cemter	4b. City, Town, or Location of Death LaPlata		4c. County of Death Charle	S			
Funeral Director			If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth 2, (Month, Day, Ye)	ear) Cour	place (State or Foreign htry) nsylvania			
aryland a-f show fied at	Director	10a. State 10b. County 10c. City, Town or Loca Maryland St. Mary's Piney Po:			,	10d. Inside City Limits 1 ☐ Yes 2 🛣 No			
with the M s 23a or 28 ust be noti	Funeral Dire	10e. Street and Number P.O. Box 110	10f. Zip Code 20674	10g	g. Citizen of What Cou USA				
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.	þ	Armed Forces? 195/- If Y 1 Never Married 2 🕱 Married 1 🛣 Yes 2 No 60	as Decedent of Hispanic Origin? (Sper /es, specify Cuban, Mexican, Puerto F Yes 2 🙀 No Specify:		14. Race - Americ Black, White, Specify:				
21215-0036 within 72 hours after giene. "natural", o her than "natural", o	Completed	(Specify only highest grade completed) (Give kin	nt's Usual Occupation Id of work done during most of workir NOT use retired		Kind of Business/Industry Ited Airlines				
and 2.	To Be C	17. Father's Name (First, Middle, Last) Samuel Grooms	d Planner 18. Mother's Name Kather	e (First, Middle, Maid		ines			
Maryland 12 should be filed lith and Mental Hy 27 is marked oth		19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing	Address (Street and Number or Rural	ess (Street and Number or Rural Route Number, City or Town, Spx 110 Piney Point, Maryland					
Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or other		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	tory or other place)		c. Location - City or To Cheltenham				
Balti permit. Departn Imports any inju		21. Signatur Funeral/Service Licensee 22. N	Name and Address of Facility Georg 50 Oxon Hill Rd.	ge P. Kala Oxon Hill	as Funeral	Home PA 1 20745			
Physician/		23a. Pad. Enter the disease, or complications that caused the death. Do not enter to shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition ACUTE RESPIRATOR)	the mode of dying, such as cardiac or		,	Approximate Interval Between Onset and Death			
Medical Examiner		resulting in death) Due to (or as a consequence of): ATRIAL FIBRILLAT: b. ATRIAL FIBRILLAT:	ION						
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760 cate be executed physician and s the burial-transit	dicalE	resulting in death) Last Due to (or as a consequence of): d.							
Box 68 death certifine attending ed for use ar	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ E	Ectopic pregnancy Other (specify)		23d. Date of deliv Month	ery Day Year			
Records, P.O. In the law requires that the late has been signed by the page 2 should be detach	d by Pi	Part II. Other significant conditions contributing to death but not resulting in the und CHF, Chronic Renal Insufficiency, Hy	, 0		co use contribute to the				
cord	Completed by	Hypothyroidism, Pulmonary Hypertens	ion,	24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of			
Vital Reco ysician: The law is certificate has be director, page 2 s	Be Cor	Clostridium Difficile 25. Was case referred to medical examiner?	26. Place of Death (Check	performed 1 Yes 2 2 only one)		2 🗆 No			
Of Vij	ျ	1 ☐ Yes 2XXNo Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 27. Manner of Death 28a. Date of injury 28b. Time of		me 5 Residence	e 6 Other (Specify)			
Division of Vital Records, Hospital or Attending Physician: The law requires 24 hours after death. Funeral Director: After this certificate has been signetly filled in by the funeral director, page 2 should be	Certificate:	1XX Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No	28f. Location (Street City or Town, St	t and Number or Rural	Route Number,			
Div To the Hospital or within 24 hours afte To the Funeral Div completely filled in	Medical C	29a. Certifier (Check 1 X Certifying Physician: To the best of my knowledge, death occ (Check 2 Medical Examiner: On the basis of examination and/or investigation.	curred at the time, date and place, and	d due to the cause(s) and manner as state	ed.			
To the H within 24 To the F complet	Me	only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, de 29b. Signature and title of certifier	eath occurred at the time, date and place 29c. License number	ce, and due to the ca	ause(s) and manner as s Date signed (Month, i	stated.			
12/2/2		30. Name and address of person who completed cause of death (Item 23a) (Type, Prin	D71199		11/26/2012	2			
Sta	te_	Josjin Vazhappilly MD 6934 Aviation I		Burnie,	MD 21063	[
Registr		NOTV 28 2012 Some B. Sa	Mal						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40672 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ PAUL BERNARD HANRAHAN 11/26/2012 9:08 a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 700 PORT ST. UNIT #516 EASTON **TALBOT Funeral** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Birthplace (State or Foreign Country) Months (Month, Day, Year) Director 206-24-1109 1 X M 2 □ F 81 10/29/1931 SHARON, PA in then "netural", or Items 23e or 28a-f show the Medical Examiner must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director **TALBOT** 1 X Yes 2 No MD EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 700 PORT ST. UNIT #516 21601 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 X Yes 2 No Black, White, etc. 2 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) DIRECTOR OF MARKETING CHEMICAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental F a JAMES BENEDICT HANRAHAN MARGARET MARY WIESEN .. Page 1 and 2 should tment of Health and N tent: If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27640 VILLA RD. EASTON, MD 21601 PAUL HANRAHAN/SON 20a. Method of Disposition 20c. Location - City or Town, State Department of H Importent: If its eny Injury or of once. CHESAPEAKE: CREMATION Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/28/2012 STEVENSVILLE, MD CENTER Musicral Service . Sign PENEROWS GOTHER FENDEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST. EASTON, MD 21601 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ CACCINOMA disease or condition resulting in death) MUNITI Medical Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): e Hospital or Attending Physicien: The law requires that the death certificate be executed 124 hours after death.

• Funeral Director: After this certificate has been also as the continued by t anding physician end use as the burlal-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burla Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month ☐ Yes 2 ☐ No ed by the a 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy 1 🗆 Yes 2 No 2 No 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Mann Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide 1 Tes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. D Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 76 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LUDWIG J. EGLSEDER, III, MD 503 CYNWOOD DRIVE, EASTON, MD RS 21601 20+1VA State Registrar

			Please	Type or Pri	nt in Bl	ack Ir	idelible In	k. Ens	ure A	II Copie	s Are	Legible	e. ,	
		-	For State Registrar	1ental Hy	giene Reg. No		40673							
ı	Physicia Medic		1. Decedent's Name (First, Middle, Las Marian Y. Henn	nger						2. Date of De Novemb		.6, 2 01	3. Time of Death 2:01A. M	
.4.	Examin		4a. Facility Name (if not institution, give Hart Heritage	street and number)			4b. City, Town, o					County of De Parford		
	Funeral Director		5. Social Security Number 6. Se	7. Age	ge (In yrs. last birthday) 88 Yrs. If Under 1 Year If Under 24 Hrs. 8, Date (Months Days Hours Min. Marc					8. Date of Bir Month, Da March	rth 21,19	9. E	Birthplace (State or Foreign Country) Ennsylvania	
	f show	tor	10a. State 10b. County		10c. City, T								10d. Inside City Limits	
	or 28e-	Funeral Director	Maryland Harford 10e. Street and Number		Fore	st Hi	10f. Zip Code		-		10g. Cit	tizen of What (1 ☐ Yes 2 💢 No Country?	
	be filed within 72 hours efter death with the Marylend entel Hygiene. ked other then "netural", or items 23e or 28e-f show tic event, the Madical Examiner must be notified at its event, the Madical Examiner must be notified at	neral	434 Dellcrest Dri				21050					ited St		
9036		Completed by Fu	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ※ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates.	ever in U.S. No	1	Vas Decedent of H f Yes, specify Cub ☐ Yes 2 🛱 No	an, Mexica	n, Puerto	ecify Yes or No- Rican, etc.)		14. Race - An Black, Wh Specify:	nerican Indian, nite, etc. White	
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land	0 5 5 0	To Be	17. Father's Name (First, Middle, Last) Ralph E. Yost							-	t, Middle, Maiden Sumame) Lia Shuey			
, Maryland 21215-0036	shou end is m		19a. Informant's Name/Relationship (7) David Paul Hennir		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2 434 Dellcrest Drive Forest Hill, Maryla						zip Code) and 21050			
Baltimore,	permit. Pege 1 and 2 Depertment of Heelth Importent: If Item 27 eny injury or other tr once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	y)	cen	letery, cren Lincol	sition (Name of natory or other pla n Cemetery		11/2	Date 29/2012	Bre	entwood	or Town, State 1, Maryland	
Ball	Depermit Deperd Import eny in		21. Sign tup of Fun val Service Licent	ee		D2	Name and Addre Dna Id V• •00 Powde	Borgw r Mil	Ardt 1 Ro	Funera	al Ho	me, PA	ryland 20705	
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09	9 9 7	اھا	that initiated events resulting in death) Last	Due to (or as	a consequer	nce of):								
. Box 68760	th cer ttendi or use	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal d	leath 3	Ectopic pregnar Other (specify)	су				23d. Date of Month	delivery Day Year	
ls, P.O.	uires that the dee n signed by the e uid be detached f		Part II. Other significant conditions of	ontributing to death b	out not result	ing in the u	enderlying cause g	iven in Part	t I.				to the cause of death?	
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	n 24 hor n 24 hor ne Fune oletely f	Medical	(Check 2 Medical Exam	sician: To the best of iner: On the basis of e se Practitioner: To th	xamination a	nd/or inves	tigation, in my opin	ion, death o	occurred a	t the time, date	and place	e, and due to the	ne cause(s) and manner stated.	
	0 g a g g		29b. Signature and title of certifier	An MA			29c. Licen	se number	29		29d. Da	ate signed (Mo	nth, Day, Year)	
	1		30. Name and address of person who	completed cause of d	leath (Item 2	3a) (Type, f	Print)	100	<u> </u>	Roln.	R	MN	2014	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registr	ar's Signatur	be	exter.	ПД	1, /	JEINI			5-11	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month Dorothy Hardesty М 201 9:50 Medical November 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 219 Bloomsbury Square Apt. Annapolis Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 217-24-6363 Director 88 1 M 2 K F 26 1924 Maryland eb. th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 No Marvland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 219 Bloomsbury Square Apt. 21401 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian. Armed Forces

1 ☐ Yes 2 ☑ No Black, White, etc. Completed by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black If Yes, Give Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th 0 Laundry US Naval Academy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F ည Roland Brown Eliza Giles and 2 should be Health and Mereten 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $2\,1\,4\,0\,1$ permit. Page 1 and 2 Department of Health Important: If Item 27 any injury or other tr 219 Bloomsbury Square Apt. B Annapolis, Md. Denise Gibbs (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Bestgate Mem. Park 11/29/12 Annapolis, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Wm. Reese & Sons Mortuary,
1922 Forest Dr. Annapolis, Approximate Interval P 23a. Part 1. Enter the disease, or comilications that caused the death. Do not enter shock, or hear failure. List only one cause on each line. dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Que to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2☐ Fetal death
☐ Pregnant at time of death
☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day P.O. signed I d be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, Completed 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 ☐ Yes 2 ☐ No ☐ Yes 25. Was case referred to medical Division of Vital director, Be 26. Place of Death (Check only one) 1 🗌 Yes 2 X No Other: မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident injury 5 Pending after death Director; A Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide within 24 hours after
To the Funeral Directory completely filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death obtained at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29b. Signature and title 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200g 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Emma Marie Harris 206 Yovembe Medical 4a. Facility Name (if not institution, give street and number 4b. City, ocation of Death County of Death **Examiner** Dorches TEMERO Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth 7. Age (In vrs. **Funeral** Day, Year) -1919 1 □ M 2 🔀 F Months Hours 93 212-16-7632 Director -04-Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 1 X Yes 2 No MD Dorchester Cambridge 10e. Street and Number 10f Zin Code ŏ 10g. Citizen of What Country? Examiner must be Funeral items 23a 1633 Race Street 21613 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Black, White, etc. ō þ 1 Never Married 2 Married 2 X No Yes Baltimore, Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: "natural" 3 St Widowed 4 Divorced Completed White event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Seconday (0-12) College (1-4 or 5+) 11 Bookkeeper Retail Jewelry is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental မ Page 1 and 2 should be ment of Health and Ments Herbert Mills Annie Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 Sandra Foxwell/daughter Governor's 502 Ave. Cambridge, MD 21613 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) Midshore Center 11/21/12 Cambridge, MD permit. 21. Signature of Funeral Service Licenses яu 308 High Street Newcomb&Collins FH Cambridge 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 10can disease or condition Medical resulting in death) Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 3 Probably 4 Unknown Completed No plnods 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy page 2 certificate 1 Yes 25. Was case referred to medical director. 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 1 🗀 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 28a. Date of injury (Month, Day, Year) . Manner of Dea 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred After 5 Pending injury 1 Natural 1 Yes 2 🗆 No 24 hours after death. Funeral Director: A 2 Accident within 24 hours after death

To the Funeral Director: A
completed filled in by the f Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 🔛 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 □ the only one) 29b. Signature and title o 29c. License numbe 29d. Date signed (Month, Day, Year) ٥

Registrar

State

30. Name and addre

gene

's Signature

rson who completed cause of death (Item 23a) (To

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ann L. Hudak November 2017 2:27 P M Medical. 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 202 South Regulator Drive Cambridge Dorchester Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last hirthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Director 047-03-1007 97 1 □ M 2 🕅 F May 31, 1915 Connecticut Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director MD Dorchester Cambridge 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 202 South Regulator Drive 21613 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 🖟 No Specify: 3 N Widowed 4 □ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Office manager Manufacturing 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eventee. Mental ဥ Joseph Melechinsky Mary Walko 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Harp daughter 202 South Regulator Dr., Cambridge, MD 21613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Crematory of Delmarva 11/16/12 Delmar, DE 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home, P.A. 700 Locust St., Cambridge, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ erchro disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and thed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12-months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Pregnant at time of death Day signed by the a g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been significate, page 2 should 1 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No Yes 2 N 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Magner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, geath occurred at the time, date and place, and due to the cause(s) and manner as stated as Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated as Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated as Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated as Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated as Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated as Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated as Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated as Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated as Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as the cause of the cause 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one 29b. Signature a d title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPXE Courte GASTAL 31. Date filed (Month, Day, Year) State 32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G935 1/03/2013 JH
State of Maryland / Department of Health and Mental Hygiene 20 | 2 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 25 Ingalls Marjorie Ann 7:35AM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 646 Kensington Avenue Severna Park Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) S298°244-7563 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Min. Days Months Hours 295-12-9543 Director 1 🗆 M 2 💢 F 82 April 15,1930 Ohio ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Severna Park 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 646 Kensington Avenue 21146 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. by 1 Never Married 2 X Married Maryland 21215-0036 Specify: White If Yes, Give 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Teacher 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Public School System Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with h and Mental Hygien 7 is marked other th Organist-Choirmaster Church Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) rmit. Page 1 and 2 should be f spartment of Health and Menta portant: If item 27 is marked y injury or other traumatic ev ည Ralph Herbert Stone Marjorie Abbott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David M. Ingalls/ Husband 646 Kensington Avenue Severna Park, MD 21146 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or oth Date 1 Durial 2 X Cremation 3 Removal from State cemetery, crematory or other place) November 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, INC. 2012 Baltimore, MD 21. Si ure of Fu ral Servic Lice 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home
495 Ritchie Hwy, Severna Park, MD 21146 Enter the disease, or cor plic from that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only line lause on each line. Approximate Interval Between Onset and Death mmediate C tuse (Final Dementia Physician disease or condition resulting in leath) Medical Due to (or as a consequence of) Examiner quentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease Or Injury that initiated events Due to (or as a consequence of) Exami Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 38 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Disease 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has to page 2 s autopsy perform Yes 2 No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA ပ within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred the Hospital or Attending injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 26 D57531 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8601 Veterans Hway modersville, mD

Registrar

31. Date filed (Month, Day, Year)

32. Redistrar's Signature

		For State Registrar		Stat	e of M	arylan		artment of rtificate of			lental Hy	gien Reg N	e 2012	2 406	7
Physicia	n/	1. Decedent's Nan		ŕ							2. Date of De	ath		3. Time of Death	
Medic Examin	al	4a. Facility Name (COHEE if not institution,		number)			4b. City, Town,	or Location	n of Death	MT 18		c. County of Dea	6:25 P	М
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Funeral Director		5. Social Security 1 220-26-1		6. Sex 1 ☐ M 2 🕽	7. Ag	e (In yrs. Ia 84	ast birthday) Yrs.	Months Days		er 24 Hrs. Min.	8. Date of Bir		9. Bir	thplace (State or Fore	igr
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene and University if them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fi	uneral Service L	mer			4						FUNERAL MD 2160	HOME, P.	A.
hysician/ Medical Examiner the prigi-transit	edical Examiner	23a. Part 1, Enter	the disease, or art failure. List o (Final on onditions, mmediate erlying ts	a b	hat caused on each line	d the death e.	AGE pence of):	TOEM				rest,		Approximate Interval Between Onset and Death	_
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ospital of Att		3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could r determi	ned 28e. P	Place of Injudication			eet, factory, office		2	28f. Location (S City or Tow			ral Route Number,	
n 24 hou n 24 hou ne Funer	Medical		2 Medical E	xaminer: On the	e basis of e	xamination	and/or inves	tigation, in my opin	ion, death	occurred at	the time, date a	and plac	and manner as sta ce, and due to the e(s) and manner as	cause(s) and manner st	ate
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** ellani S. lean ocember /Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 💢F Months Oct. 20, 1967 45 New York 129-64-6069 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show must be notified at Fulton Maryland Howard 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ö 7224 Preservation Court 20759 United States 23a Funeral items 2 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc nit. Pages 1 and 2 should be filed within 72 hours after cartment of Health and Mental Hygiene.
ortant: If item 27 is marked other than "natural", or iten injury or other traumatic event, the Medical Examiner. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 2^{College (1-4 or 5+)} Elementary/Secondary (0-12) Medical Hospital Administrator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Roger Jean Leilani David မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Baptiste -cousin 7224 Preservation Court Fulton, Maryland 20759 20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory11/26/2012 Alexandria, Virginia 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of H
Important: If iter
any injury or oth 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature / Funeral Service Licens Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 Part 1. Enter the disease, or construction of the shock, or hear failure. List on the shock is the shock of t Approximate Interval Between Onset and Death plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical to or as a consequence of) Examiner Due to (or as a construence fi): Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) physician and street prices and the puriant Division of Vital Records, P.O. Box 68760, by Physician/Medical attending 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Tectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 1 Yes 2 No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 2 No 3 Probably 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 XInpatient examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To Director: After this d in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d, Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury 1 Tes 2 No Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours of the Funeral I 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (check only one) and manner stated 29b. Signature and title of certifier 29c. License number 125100 Min November 24, 2012

Registrar DHMH 17 Rev 1/2001

State

4940 Eastern Avenue, Baltimore, MD, 21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bach

MD

32. Registrar's Signature

Christopher

31. Date filed (Month, Day, Year) NOV 2 8 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2, 40 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ANNE ARUNDEL ANNAPOLIS ANNE ARUNDEL MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, JULY 9 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours RHODE I SLAND 1 X M 2 □ F 85 Director 1927 <u>57</u>9-24-5363 Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 ☐ Yes 2X No MARYLAND ANNE ARUNDEL ANNAPOLIS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be n Funeral 810 MONROE STREET 21403 UNITED STATES 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces Black. White, etc. 5 þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. NAVY 1 ☐ Yes 2X No Specify: Specify: WHITE "natural", 3 Widowed 4 X Divorced Completed 27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 REALTOR REAL ESTATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filk tment of Health and Mental tant: If item 27 is marked o and Mental ပ WALTER JASEPH ROSALIE BROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2: Department of Health Important: If item 27 any injury or other troones. JAMES JASEPH / 2049 HAVERFORD DR. CROWNSVILLE, MD 21023 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/27/2012 STEVENSVILLE, MD TRIBUTES BY FELLOWS, EMATION & FUNERAL CARE LIS, MD 21401 22. Name and Address of Facility LASTINGSignature of Funeral Service Ligense & RD Tart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death ONGESTT Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical yes, outcome of pregnancy
Live Birth 2 Fetal death 3 Ectopic pregnancy
Company at time of death 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Box (in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by UNG Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 X No မ 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner/To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier MD DAVULURI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAD MAN ANNE ARUNDEL MEDICAL CTR, 2001 MEDICAL PARKWAY, ANNAPOLIS, MD -2140/. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

HAROLD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Kay Elizabeth McSteen Jones 2012 1:52 a^M November Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death Anne Arundel Annapolis Anne Arundel Medical Center 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthdav) **Funeral** 1 □ M 2**X** F Months Hours Min Feb. 28 Yrs 1941 Director Pennsylvania 71 <u>070-32-6141</u> Usual Residence of Deceden 28a-f shov aţ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director Stevensville "natural", or items 23a or 28a-f s edical Examiner must be notified MD Oueen Anne's 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21666 101 Cove Creek Court 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Specify: Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) ulth and Mental Hygiene. 27 is marked other than "I r traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Owner/Operator Racquetball Club Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important; if item 27 is marked to any injury or other traumatione. 2 Elizabeth Githens Arthur J. McSteen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 Cove Creek Court Stevensville, MD 21666 19a. Informant's Name/Relationship (Type, Print) Richard C. Jones, Jr./Husband Date 23, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Nov. 2012 1 Burial 2 X Cremation 3 Removal from State Baltimore, MD Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Livense 22. Name and Address of Facility
Rarranco & Sons, P.A. Severna Park Funeral Home
495 Ritchie Hwy. Severna Park, MD 21146 rt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediat Cause (Final disease r condition resuling in death) Onset and Death Pnysician/ ar Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the 38 IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months? Day Month Year Yes 2 No be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed' death? certificate 1 Yes 2 No Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? 1 Tyes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 400 ٩ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of . After t Certificate: 28c. Injury at 28d. Describe how injury occurred **Natural** 5 Pending work death. 1 Tyes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be after death filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral I Medical (Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of co 29c. License number

Registrar

State

30. Name and addre

31. Date filed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

m

2001

Herbert

NOV 2 8 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40682 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 2012 8:05 P M Albert Edward Lemke D<u>ecember</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 40404 Waterview Drive <u>Mechanicsville</u> Mary's If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Director 579-16-5864 1 M 2 □ F 89 09/16/1923 Washington, DC d Mentel Hyglene. marked other then "natural", or items 23e or 28e-f show imetic event, the Medical Examiner must be notified at 10a. State 10b. County filed within 72 hours after deeth with the Marylend 10c, City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No St. Mary's Mechanicsville Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20659 USA 40404 Waterview Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Š 1 ☑ Yes 2 ☐ No If Yes, Give Saltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Home Construction t. Page 1 end 2 should be filed with trant of Health and Mentel Hyglei rtent: If Item 27 is marked other I njury or other traumetic event, III Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Victoria M. Herman Lemke Benjamin Rudolph Lemke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Connie Gilcrist / Daughter 9709 Woodland Avenue, Seabrook, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1.
Department of I Importent: If It eny Injury or of once. 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Memorial Garden 12/7/12 Waldorf, Maryland 21. Signature of Furneral Service Ligenses M00817 22. Name and Address of Facility Brinsfield-Echols Funeral Home douten Echals 20624 30195 Three Notch Road, Charlotte Hall, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition Medical resulting in death) Due to (or as onsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of ettending physician end for use es the burlal-transi or Attending Physician: The lew requires that the deeth certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 C Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Year Pregnant at time of death been signed by the e should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes autopsy performed? After this certificate 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funerel Director: Afte completely filled in by the fun 5 \square Pending 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier 1 🔀 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) son who completed cause of death (Item 23a) (Type, Print) 30 Name and address of pe

DHMH 17 Rev 06-2011

State Registrar

5+1 ene

Jennifer Schmidt,

31. Date filed (Month, Day, Year)

32. Registrar's Signature

40900 Merchants Lane, Leonardtown, MD

20650

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No 2 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 12 2012 Barbara Ann Lumpkins 6:50 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death St. Mary's Hospital St. Mary's Leonardtown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Director 212-66-7444 1 🗆 M 2 🔀 F 82 08/17/1930 Maryland Usual Residence of Deceden 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No St. Mary's Maryland | Avenue 10e. Street and Number 10a, Citizen of What Country? 23a Funeral 20609 USA 21038 Golden Thompson Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Yes 2 No If Yes, Give Year or Dates. "natural", or 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify Completed 3 X Widowed 4 Divorced Specify: White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life, DO NOT use retired) during most of working and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Board of Education Food Service Worker 12 other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If item 27 is marked any injury or other traumatic and once. မ James Oakley Tippett Gertrude Buckler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20609 21038 Golden Thompson Road Avenue, MD Bonnie Sue Lumpkins/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial Grds 12/07/2012 Leonardtown, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Gardiner Funeral Home, Jardiner 41590 Fenwick Street Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ SEPSTS disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** 4 WKS TRACT FNEETZON URTAINRY Sequentially list conditions, Examiner Due to (or as a nonsequence of) cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Day igned by the at be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPOTHERMIA 1 Yes 2 No 3 Probably 4 Unknown page 2 should HYPOGEYCIEMIA Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 Yes Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No the 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

Division of Vital Records, P.O. Physician:

Maryland 21215-0036

Baltimore,

within 24 hours after death. To the Funeral Director: A completely State

3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of

25500 POINT LOOKOUT

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12/03 ZUIZ 20650

WRUCE RUSKRT GIRSON MP 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Registrar

Medical

29a. Certifier

(Check

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2:25 P M <u>December</u> 2012 Michael Leck Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 16692 Swanson Cove Court Hughesville Charles 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours Min. Director 084-20-7492 1 🕅 M 2 🗆 F 84 Yrs. 09/17/1928 Greenport, NY 1 end 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. items 7 is marked other then "netural", or items 23a or 28a-f show other treumatic event, the Medical Evariner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Hughesville MD Charles 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 16692 Swanson Cove Court 20637 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 🖾 Yes 2 🗆 No If Yes, Give Black, White, etc. Š 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Midowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) U.S. Marine Corps Master Gunnery Sergeant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Paraska Holobusky Gregory Harry Leck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 end 2 Department of Health Important: If item 27 any Injury or other tr 16692 Swanson Cove Court, Hughesville, MD 20637 Susan (Leck) Fleming / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 02/14/2013 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Arlington Ntl Cem. Signature of Funeral Service Light 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. **№**M01458 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. art 1. Enter the dise lie of complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examin inding physiclan end use es the burial-transit The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 yes, outcome of pregnancy Live Birth 2 Fetal death 3 Ectopic pregnancy Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant for in the past 12 months? 1 Yes 2 No Month Day 5 Other (specify) signed by the a 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 2 🗆 No 24 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospitel or Attending Phys within 24 hours after death. To the Funeral Director: After this of completely filled in by the funeral direction. After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical TCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

of Vital Division

12+1 rema State

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

2000 32. Pegistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type-Print) Dr.

6

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License numbe

Krishan, Mathur

29d. Date signed (Month, Day, Year)

Registrar

r /			Plea				Indelible In		•		e _	
	_	For State Registrar					ertificate of l			Reg. N	2012	
Physicia Medic		1. Decedent's Nam	,	Last)	Li	inder			2. Date of De		Day 2012 ^{Year}	3. Time of Death 1:45a M
Examin	er	4a. Facility Name (in		and Reha			4b. City, Town, o	r Location of Death \mathbf{n}			lc. County of Dea Anne Aru:	
Funeral Director		5. Social Security N 086-26-7		6. Sex	7. Age (In yrs. la	ast birthday, Yrs.) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	ay, Year)) Co	thplace (State or Foreign untry)
ind show at	or	Usual Residence	of Decedent 10b. County			y, Town or L	ocation		Dec. 18	3,19	932 Ne	W Jersey 10d. Inside City Limits
e Maryla r 28a-f s notified	Funeral Director	MD 10e. Street and Nur		runde1			An	napolis		10: 0		1 🗆 Yes 2 🛣 No
n with th	neral	930 Bay		Court				1403		TUg. C	Oitizen of What Go	ountry?
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Mari 3 ☐ Widowed		12. Was Dece Armed Fo 1 Yes If Yes, Giv Year or D	edent Ever in U.S proes? 2 X No re ates.	S. 13	. Was Decedent of H If Yes, specify Cuba 1 Yes 2 X No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit Specify: W	
in 72 hou e. han "natu Medica	Completed	(Spe	ecify only highe:	t's Education st grade completed, College (1		(Giv	edent's Usual Occup e kind of work done o DO NOT use retired)	during most of work	ing	16b. Kind of Business/Industry		
filed within the Hygiene I other the vent, the	Be	17. Father's Name	(First, Middle, L	ast)			Customer	Service 18. Mother's Nam	e (First, Middle,	_		Airlines
ould be to define the marked marked imatic e	မ	Aller	n B. La:			19h Mai	iling Address (Street		ie Lyma		or Town State 7	n Code)
and 2 shu Health ar Im 27 is her trau		Stacey	Fallon/	'Daughter	lan a	6688	Stonebro	ook Drive	,Clifto	n, V	/A 20124	
Page 1 ament of hament of hamt: If ite			Cremation 5 Cother (S	3 ☐ Removal from pecify)	State C	_{emetery, cr} i	oosition (Name of ematory or other place cematory	Nov.		Ва	Location - City or altimore	
permit. Depart Import any inj once.		21. Signature of Fu	ineral Service Li	ensee	?		22. Name and Addre	^{ss of Facility} Bea	11 Fune Bowie,	ral MD	Home 20715	
Physician/		shock, or hea Immediate Cause disease or condition	art failure. List o (Final	nly one cause on ea			nter the mode of dyin	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
Medical Examiner		resulting in death)		C	(or as a consequ OPD	ience of):						
ecuted and II-transit	xaminer	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	mmediate erlying injury	b. Due to	or as a consequ	ience of):				_		
e be execut ysician and ne burial-tra	ш	that initiated event resulting in death)	1 1	Due to	(or as a consequ	consequence of):						
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	1 Live	tcome of pregna Birth 2 Feta nant at time of c	death 3	☐ Ectopic pregnand	су			23d. Date of de Month	slivery Day Year
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The la icate he or, page		Hypoth	nyroidis	sm					perfo 1 ☐ Yes	ormed?	death?	s 2 No
ysiciar s certif directo	To Be	examiner?		Hospital:	Inpatient 2 🗆	ER/Outpati	Oth	er: 4 X X Nursing H		dence	6 Other (Spec	cify)
eath. or: After thi the funeral	Certificate: 1	27. Manner of Deat 1 A Natural 2 Accident 3 Suicide	th 5 Pending Investig 6 Could r	28a. Date (Mon ation		28b. Time injury	of 28c. Injur	y at	28d. Describe			
tal or Atress after of all Direct	I Cert	4 Homicide	determi	ned 28e. Place	of Injury - At ho ing, etc. (Specify		treet, factory, office		28f. Location (City or To			ral Route Number,
ne Hospi in 24 hou ne Funeri pletely fill	Medical	(Check 2	2 Medical E	xaminer: On the ba	sis of examination	n and/or inve	n occurred at the timestigation, in my opinione, death occurred at	on, death occurred a	t the time, date	and plac	ce, and due to the	cause(s) and manner stated
To the withing the complete co		29b. Signature and	title of certifler	11/10	1	MI	29c. Licens D 006				vember 2	
310		30. Name and addr					Print) 1 B1vd. Su	ite B, G	len Bur	nie,	, MD 210	51

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year) NOV 2 7 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

40686 State of Maryland / Department of Health and Mental Hygien [9] For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 5 Edward V. Migdalski December 2012 12:07 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Emittsburg, Maryland C

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) St. Catherine's Nursing Home Carrol1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□ F 88 Yrs. Director 094-12-7943 New York January 31. 1924 Usual Residence of Decedent the Maryland 10c. City, Town or Location r 28a-f ehow 10a. State 10h. County 10d. Inside City Limits PA 1 ☐ Yes 2 🖾 No Adams Littlestown Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ral', or iteme 23a or 949 Gettysburg Road 17340 United States of America death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after toent of Health and Mentai Hygiene. Int: If Item 27 ie marked other then "natural", or Ites 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 X Widowed 4 Divorced Completed The Madical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Electric Engineer Engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Valentine Migdalski 2 Anna Santysiak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose Schmitt / Niece 5314 Chestnut Ridge Rd, Orchard Park, New York 14127 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If Ite any Injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-6-2012 Cremation Society of PA Harrisburg, PA 17109 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Auer Cremation Services of Pennsylvania, In 4100 Jonestown Rd, Harrisburg, PA 17109 1 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury requence of): Examiner rsicien and e burial-transit The law requires that the death certificate be executed P.O. Box 68760, resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical the t attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete hes to irector, page 2 si autopsy performed? 2 2 No 1 Yes Division of Vital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation within 24 hours after death. To the Funerel Director: A 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide To the Hospital 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of dertifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

arrol

2012

31. Date filed (Month, Day, Year)

32. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40687 State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 8:40P Mildred Ann Minichino December 2013 Medical 4a. Faeility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death of Death ENTER LATA 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) g. Birthplace (State or Foreign Min 040-20-8714 **Director** 1 🗆 M 2 🖾 F 86 06/03/1926 Connecticut ms 23a or 28a-f show must be notified at 10b. County with the Maryland 10a. State 10c. City, Town or Location Director MD Charles 1 Yes 2 No Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 20601 United States 2255 Westwood within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give 11. Marital Status 14. Bace - American Indian Examiner Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White Completed 3 X Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) id Mental Fyglene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12 Manager Montgomery Wards Bie filect 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be Anthony Camposano Anna Ruotolo . Page 1 and 2 should tment of Health and N tant: If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9305 Luftschloss Dr., Pomfret, MD 20675 Linda A. Liston/Daughter altimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ō 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place. Important: If any injury or once, permit. Page Department 4 ☐ Donation 5 ☐ Other (Specify) Joseph's Chur 12/07/12 Pomfret, MD Signature of Funeral Service Lice 22. Name and Address of Facility Raymond Funeral Svc., M01517 &amo La Plata, 20646 5635 Washington Ave., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Onset and Daath Immediate Cause (Final Physician/ disease or condition N Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s performed Yes 2 certificate 2 🗌 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: ပ္ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Mor 2012 UM death (Item 23a) (Type, Print) 30. Name and address of person who completed

31. Date filed (Month, Day,

Centennial St. LAPLATA Md 20646

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 40688 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Annie Morgan November 29, 2012 9:55 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Nursing Center St. Mary's Leonardtown Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 219-48-4062 **Director** 1 M 2 XF 94 11/28/1918 Usual Residence of Deced Maryland show 10a. State the Maryland notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 🗌 Yes 2 🛣 No Maryland St. Mary's Avenue 10e. Street and Number ms 23a or must be r ò 10f. Zip Code 10g. Citizen of What Country? Funeral 27575 Paul Ellis Road 20609 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ö 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", Completed 3 ₩ Widowed 4 □ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 8 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of 2 permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Mary Lillian Graves Noble Edward Farrell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose Ann Friess/ Niece 22864 Maddox Road Bushwood, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Removal from State 12/5/2012 4 Donation 5 Other (Specify) Sacred Heart Bushwood, MD 21. signature of Funeral Service Liver Name and Address of Facility Mattingley-Gardiner Funeral Home, I 41590 Fenwick St., Leonardtown, MD Jichael 0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final (alon Concer Physician disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Pollure dothrive Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury that initiated events Coronory odery disoble burial-trar Due to (or as a consequence of) resulting in death) Last physician Physician/Medical that the death certificate be P.O. Box 68760 the use as attending | IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed plnods 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 2 No 욘 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Wursing Home 5 ☐ Residence 6 ☐ Other (Specify, I hours after death.

uneral Director: After the filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I completely filled Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11/80/12 D070900 kusindeed 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GLA BUMPE MD 2106 5) Rmu 31. Date filed (Month, Day, Year) 32. Régistrar's Signature State DEC 0 3 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2

		For State Registrar	State of Mar		artment of F			iene 20	12 40689
Dhyoic	ion/	Decedent's Name (First, Middle	, Last)				2. Date of Deat Month		3. Time of Death
Physic Med	lical	Victoria		Medsker	A.K.A.		Novembe	er 30,	2012 9:50 A ^M
Exam	iner	4a. Facility Name (If not institution 22810 Dorsey				r Location of Death rdtown		4c. County St.	of Death Mary's
Funera	_	5. Social Security Number		n yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)
Directo	r	514-42-8794 Usual Residence of Decedent	1 🗆 M 2 🗷 F	68 Yrs.			09/23/1	944	California
and show	Ď	10a. State 10b. County	1:	0c. City, Town or Lo	cation				10d. Inside City Limits
Mary 28a-f otifie	Director		Mary's			onardtow	n		1 X Yes 2 No
th the	a D	10e. Street and Number			10f. Zip Code		1	0g. Citizen of V	
ms 2	Funeral	22810 Dorsey S	12. Was Decedent Eve	rin I ! C 13		20650	ecify Ves or No-	14 Pag	USA e - American Indian,
or ite	by Ft	1 X Never Married 2 Mar	Armed Forces?		Was Decedent of H If Yes, specify Cuba		Rican, etc.)		e - American Indian, k, White, etc.
O3(3 🗆 Widowed 4 🗆 Divorced	If Yes, Give Year or Dates.		1 ☐ Yes 2 🛣 No	Specify:		Specify:	White
15-(2 hou "natu	plet		nt's Education est grade completed)	(Give	dent's Usual Occup kind of work done	during most of work	ing	16b. Kind of Bu	usiness/Industry
21215-0036 within 72 hours after glene. er than "natural", o ;, the Medical Exam	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		ONOT use retired) puter Spe			U.S. G	Sovernment
Illed w lather other vent,	Be	17. Father's Name (First, Middle, L	.ast)		<u> </u>		e (First, Middle, N		
Vlar d be f Menta arked	은	Carl Elwo	od Medsker			Ruby	Gertrud	e Kerry	,
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationsl			ng Address (Street			_	
e, N and 2 Health em 27		Phyllis Knott/ 20a. Method of Disposition	Personal Rep	20b. Place of Dispo	10 Dorsey				m, MD 20650 City or Town, State
age 1 int of it. If it.		1 🗌 Burial 2 😾 Cremation	3 Removal from State	cometery, cre Matting Funeral Hon	matory or other place Ley_Gardine	ce)	/2012		
Baltimore, permit. Page 1 and Department of Hee Important: If item any injury or othe	si l	4 Donation 5 Other (S	pecity)	Funeral Hou					town, MD
Dep Dep any	900	Muchaels	Lardener	/ 1	Mattingl 41590 Fe	ss of Facility ey-Gardin nwick St	ier Funei , Leonai	ral Home	MD 20650
Medica Examine ysician and e burial-transit	al	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Die to (or as a co	onsequence oi).		rdiovas	es w	Gosta	minudes
Box 6876(death certificate he attending physeled for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at ting Unknown	Fetal death 3	Ectopic pregnand Other (specify)	cy		23d. Dai	te of delivery nth Day Year
P.O. that the	by P	Part II. Other significant condition	ns contributing to death but	not resulting in the	underlying cause gi	ven in Part I.			ribute to the cause of death?
ds,	ted						1 Ye		3 Probably 4 Unknown
/ital Reco sician: The law re s certificate has be director, page 2 sh	Completed					-	24a. Was ar autops perforn	ned?	Were autopsy findings available prior to completion of cause of death?
of Vital Rec. Physician: The law r this certificate has	Be C	25. Was case referred to medical			26. Pl	ace of Death (Chec	1 L Yes 2 k only one)	2 No 1	Yes 2 De Vo
Vit hysica his ce	ျ	examiner? 1 Yes 2 No		2 ER/Outpatie		4 ☐ Nursing He	ome 5 Reside	nce 6 🗆 Othe	er (Specify)
ding P	ate	27. Manner of Death Natural 5 Pendir		/ear) 28b. Time o injury	work	y at ⟨? Yes 2 □ No	28d. Describe ho	w injury occurre	ed
Division of Vital Records, To the Hospital or Attending Physician: The law requires within 24 hours after death. To the Funeral Director: After this certificate has been signormplately filled in by the funeral director, page 2 should to	Certificate:	2 ☐ Accident Investig 3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be			res 2 🗆 NO	28f. Location (Str City or Town		er or Rural Route Number,
Dival cours at eral D		29a, Certifier Certifying	hysici To the best of my	knowledge death	accurred at the time	o data and place	nd due to the cau	sea(e) and mann	per ac etated
e Hos n 24 h e Fun	Medical	(Check dical E		mination and/or inves	stigation, in my opinio	on, death occurred a	t the time, date and	d place, and due	e to the cause(s) and manner stated.
To th withir To th	2	29b. Signature and title of sertifier		>	29c. License	e number			i (Month, Day, Year)
	-		7	MS	Dia	1917		11/30	/12
Ella		30. Name and address of person	who completed cause of deat	0 -0 126	Print)	7	10.	1 - 0	1. m Md
5+1 Rme	ate	31. Date filed (Month, Day, Year)	32. Registrar's	Signaturg	485 0	essie !	d Let	shard	etown, Inch
Regis		DEC 0 5	2012 Janeur	B. A	arked				

Hospital or Attending Physician: The law requires that the death certificate be executed and attending physician Division of Vital Records, P.O. Box 68760 signed by the has 24 hours after death.

Funeral Director: After this certificate within 2 To the I

Funeral

Director

28a-f show

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items 23a

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"natural",

and Mental Hygiene. is marked other than

permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, til once.

Physiciani

Medical

Examiner

event, the Medical Examiner must be notified at

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Rme State Registrar

DHMH 17 Rev 7/2009

Medica

29a. Certifie

(Check

only one 29b. Signature ar

Stephen Patrick

30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)

0 6 2012

Cafferty,

M.D.

. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

100 Hospital Road, Prince Frederick, MD

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 24, 2012 HELEN MARUCCI November 05:35 a M R. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Sandy Spring Friends Nursing Home 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) If Under 24 Hrs 9. Birthplace (State or Foreign 94 069-09-9532 1 🗆 M 2 💢 F July 13 1918 New York Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Montgomery Silver Spring 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17008 Barn Ridge Drive 20906 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗹 No Specify. White 3 🛮 Widowed 4 🗆 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) School Kitchen Staff 9 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Michael Salerno Christina Giardino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph J. Colella/Son-In-Law 17008 Barn Ridge Drive, Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖪 Burial 2 🗆 Cremation 3 🗆 Removal from State All Souls Cemetery 11/29/12 Germantown, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Roy W. Barber Funeral Home P.O. Box 5038, Laytonsville, Maryland 20 20882 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate

Ph. sician Medical To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

Examiner Examiner burial-transi and attending physician I for use as the buria Completed by Physician/Medical signed by page 2 s has after death.

Director: After this certificate filled in by the funeral director, Medical Certificate: To Be within 24 hours a

Physician/

Medical

10a. State

MD

Examiner

Funeral

Director

or 28a-f shown notified at

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r items 23a or iner must be r

permit. Page 1 and 2 should be filed within 72 hours after death a pepartment of Heath and Mental Hygiene. Important: I firem 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m.

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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with the Maryland

Immediate Cause (Final disease or condition	a Atherosclerotic Cardiovascular D	isease	Interval Between Onset and Death
resulting in death)	Due to (or as a consequence of):		
Sequentially list conditions	Hypertension		
Sequentially list conditions,	Dale to (or as a sunsequence crys		
Cause (Disease or injury that initiated events	Hyperlipidemia		
resulting in death) Last	Due to (or as a consequence of):		
	d		
is service			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions co	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
		1 🗆 Yes	2 ☐ No 3 ☐ Probably 4 🗵 Unknown
		24a. Was an autopsy performed?	
25. Was case referred to medical examiner?	26. Place of Death (Chec	ck only one)	
1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing H	Iome 5 Residence	6 Other (Specify)
27. Manner of Death 1 S Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be		28d. Describe how inju	ury occurred
4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street a City or Town, Stat	nd Number or Rural Route Number, e)
(Check 2 Medical Examin	ician: To the best of my knowledge, death occurred at the time, date and place, a ner: On the basis of examination and/or investigation, in my opinion, death occurred a e Practitioner: To the best of my knowledge, death occurred at the time, date and p	at the time, date and place	e, and due to the cause(s) and manner stated.

29c. License number

D 39793

29d. Date signed (Month, Day, Year)

November 24, 2012

State

Registrar

29b. Signature and title of certifier

30. Name and address of person who

28

31. Date filed (Month, Day, Year)

Christopher J. Mays, M.D., 18111 Prince Philip Dr., Suite 207, Olney MD 20832

ceeps mi

pleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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п	Z-U	9240	

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

•	baco Typo of Time in Black indonbio link, Endaro 7 in Copico	
aymond Paul McDermott	State of Maryland / Department of Health and Mental Hyg	iε
1- For State Registrar	Certificate of Death	
Dhysician/ 1. Decedent's Na	me (First, Middle, Last)	Da

2	0	-	2	4	0	6	9	2
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		1- For State Registrar	Certif	icate of	Death		R	eg. No. ZU	12 4000
Physicia	n/	Decedent's Name (First, Middle,Last)				_	2. Date of Dea Month	th Day Yea	3. Time of Death
ledical Examin	ier	Raymond Paul		Mc	Dermot	t	Decembe	r 5, 2012	0415 hrs
		4a. Facility Name (if not institution, give street and number	er)	4		or Location of Deat	h	4c. County of	of Death
		Memorial Hospital			Easton			Talbot	
Funeral			lge (In yrs. last i	birthday)	If Under 1 Ye				Birthplace (State or Foreign
Director		185-48-4551 X M 2 F	50	Yrs.	Months Da	ys Hours Mi	^{n.} 03/11	1/1962	Country) PA.
	ı	Usual Residence of Decedent				1			
any.	ſ	10a. State 10b. County	10c. City, To	wn or Locatio	on				10d. 'nside City Limits
E struck	١	MD. Talbot		${f Tr}$	appe				1 Yes 2 X No
Aaryland 28a-f shnw 1 at noce.	쉵	10e. Street and Number			10f. Zip Code 21		1	0g. Citizen of Wh	at Country?
ith the Maryland 23a or 28a-f shn notified at noce.	Director	30343 Kates Point Road	i		21	673		U.S.	Α.
with t	ᡖ	11. Marital Status 12. Was Decede	nt Ever in U.S.	13. Was	Decedent of H	lispanic Origin? (8	Specify Yes or No	- 14. Race	- American Indian, Bleck,
item	Fune	1 Never Married 2 X Married Armed Force	E-min			an, Mexican, Puert		White	
ter d		3 Widowed 4 Divorced If Yes, Give Year	2 X No	1	Yes 2X N	o specify:		Specify:	White
hours afte 'natural'', Examiner	ē	or Dates: 15. Decedent's Education (Specify only highest grade or	ompleted) 16	N-West-J		ation (Give kind of	work done	16b. Kind of Bus	
2 ho	ompleted	Elementary/Secondary (0-12) College (1-4 c	r 5+)			fe. DO NOT use re	tired)	Cons	truction
within 72 jene.	힐	8 -0-]	Dump	Truck	Driver		Comb	cruccion
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	ဦ	17. Father's Name (First, Middle, Last)				18.Mother's Nam	ne (First, Middle,	Maiden Surname)	
215 e file tal H ked o	Be	John McDermott				Doro	thy Gi	caham	
Men mar	ို	19a. Informant's Name/Relationship (Type, Print)		19b. Mailing	Address (Stre				n, State, Zip Code)
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland lth and Mental Hygiene n 27 is marked other than "natural", ur items 23a or 28a-f ah numatic event, the Medical Examiner must be notified at nace	1	Jason McDermott/ Son				38 Trap			
Nore, MD 21215-0036 ages 1 and 2 should be filed within 72 nt of Health and Mental Hygiene f: If item 27 is marked other than ' inther traumatic event, the Medical	ı	20a. Method of Disposition			ion (Name of c	emetery,	Date	20c. Location -	City or Town, State
10 F	Ų	1 X Burial 2 Cremation 3 Removal from 9	State	natory or oth	. ,	12	-11-12	Trann	e, MD.
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene, Important: If tem 27 is marked other thinjury or ruther traumatic event, the Med	-	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	wnı		rsh Ce				<u> </u>
Ba Depa Injur		Tours out O to 1:	1600		_				Home P.A.
Physician	-	23a. Part I. Enter the disease, or complications that cause	ed the death. Do	not enter the	O. Bo	x 518 S	or respiratory arr	est shock of hea	MD. 21663 art Approximate Interval
/Medical	١,	failure. List only one cause on each line.						, ,	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) aA therosc1 Due to (or as a cor		Cardio	vacsula	ar Diseas	se		Deali
and the same		b	isequerice or,						
	힐	Sequentially list conditions, if any, leading to immediate Due to (or as a cor	sequence of):						
	힘	cause, Enter Underlying Cause (Disease or injury that initiated							
ed isit	Examiner	events resulting in death) Last Due to (or as a cor	sequence of):						
		X UNPENDED	27 nei	r me.o	935 1-2	5-13 sm			
760, icate be exc physician the burial	/Medical				,,,,	J 13 UI			
8760, ificate be ig physic is the bur	Š	IF FEMALE: 23c. If yes, outc				Ectopic pregr		23d. Date of	•
ox 68/ eath certific attending	Sia.		at time of death		er (Specify)	Ectopic pregi	laricy	Month	Day Year
Box 68 e death certi the attendined for use a	Physicia	1 Yes 2 No 9 Unknown 9 Unknown		o 🗀 Oill	er (opeany)			1	
at the d		Part II. Other significant conditions contributing to dea	ath but not resul	Iting in the ur	nderlying cause	given in Part I.	23e. Did to	obacco use contri	bute to the cause of death?
ires that the signed by	ğ						1 Ye	s 2 No 3	Probably 4 V Unknown
rds, requir	je						24a. Was	an 24b. V	Vere autopsy findings available
law r has b	힑						autor		rior to completion of cause of eath?
tal Rection: The certificate ector, page	Completed						1 ✓ Yes		Yes 2 No
Division of Vital Records, tat or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be.	Be	25. Was case referred to medical examiner?				oe of Death (Check			
Physical directions of the state of the stat	ှု	1 ✓ Yes 2 No	tient 2 🗹 ER						Other -
ling P		27. Manner of Death 1 X Natural 5 Panding 28a. Date of Ir (Month, Day	njury 28 r,Year)	b. Time of In	·	jury at Work?	28d. Describe	how injury occurre	ed
siOl trend death ctor:	萧	2 Accident Investigation				Yes 2 No			
Or A after after Dire	<u></u>	Suicide Could not be	Injury - At home	, farm, street	, factory, office	building, etc.	28f. Location (or Town, S		er or Rural Route Number, City
Spital spital neeral fillex	Certification:	4 Homicide determined (Specify)							
e Hn 124 h e Fu	g	29a. Certifier (Check only 1 Certifying Physician: To the best of							
Division of Vital Records, P.O. Box 68. To the Haspital or Attending Physician: The law requires that the death certivitin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use a	Medical	one) 2 Medical Examiner: On the basis of examiner and manner state	amination and/o	or investigation			at the time, date	and place, and de	ue to the cause(s)
	Σ	29b. Signature and title of certifier				nse number	A A C	29d. Date signe	ed (Month, Day, Year)
	1	Theodore Ul Kind 7	R. and	, à	0.0	.м.E. ⁰⁰	r:C	December	5, 2012
_	ŀ	30. Name and address of person who completed dause of	death (Item 23	a)				1	
		Theodore M. King, Jr., MD. Assistant	Medical Exa	ıminer 9	00 W. Balti	more Street, F	Baltimore, MI	D 21223	
Sta	ite	31. Date filed (Month Day, Ylan) 2012 32. Redist	rar's Signature	ha	N. J				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 24, 2012 1:30 Hua-Chen Miao Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 8. Date of Birth Hours (Month, Day, Year) Director 593-45-8325 80 1 🖾 M 2 🗆 F Dec. 21, 1931 China 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, <u>the Medical Examiner must be notified at</u> 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director Maryland Montgomery Derwood 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20855 7627 Moccasin Lane United States 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married δ 5-0036 1 ☐ Yes 2 K No Specify: 3 Widowed 4 Divorced Specify: Completed Asian Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) filed within 72 al Hygiene. d other than " Maryland 2121 Elementary/Secondary (0-12) College (1-4 or 5+) Engineer Utility Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental h Not Available Chung Fong He Miao 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is eny injury or other trai once. Kuei Chih Miao (Spouse) 7627 Moccasin Lane, Derwood, MD 20855 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State December cemetery crematory prother place)
Metropolitan
Crematory 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 3, 2012 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home, 10 E. Deer Park Drive, Gaithersburg, MD 20877 M00689 23a. Ran // Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or least failure. List only one cause on each line. Immediate Cause (Final disease or condition Approximate Interval Between Pnysician/ Medical resulting in death) [']Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.
Funeral Director: After this letely filled in by the funeral (28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. d title extension in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

29d. Date signed (Month, Day, Year) (Check within 2 To the P only one)

State

B

29b. Signature and title

31. Date filed (Month, Day, Year) NOV 28 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signatu

Hesh mot. MD

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November

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Research

Blud, Suite 330,

29d. Date signed (Month, Day, Year)

20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 4 0 6 9 4 State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nov. 25 201º2 Marguerite Murphy 4:40 Рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Heritage Harbor Health Center Annapolis Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months (Month, Day, Year) Country) Director 179-16-4013 1 M 2 X F 94 PA 09/14/1918 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location aţ 10d. Inside City Limits Director ems 23a or 28a-f sh r must be notified a MD Anne Arundel 1 🗌 Yes 2 💢 No Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2001 Kenwood Road 21409 USA ral", or items 2 Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force or i Black, White, etc. þ 1 X Never Married 2 Amarried 1 Yes If Yes, Give 2 X No Je filed within ...
ental Hygiene.

rrked other than "natural", o Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) or other traumatic event, the h and Mental Hygien 7 is marked other th Retail Clerk Grocery Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Murphy Catherine McCormick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health is item 27 i Joseph LeStrange (Nephew) 2001 Kenwood Rd Annapolis, MD 21409 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Department of Important: If any injury or John's Cemetery 11/30/2012 Susquehanna, PA ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home 2. 18 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): physician a s the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for Year Month Pregnant at time of death Day Unknown g Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 21 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury work? 1 🗌 Yes 2 🗆 No I Director: A Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number City or Town, State within 24 hours a
To the Funeral C
completely filled Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Nedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check dertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 30. Name and address

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40695 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MOZINGO FRANCIS Month Day Day Year NOVEMBE 22 wd 20/2 12.30 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HOSPITAL BALTIMOR MEDSTAR HARBOR If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Director 579-42-7242 1 X M 2 □ F 81 April 19,1931 Washington DC ehow permit. Page 1 and 2 should be filed within 72 hours efter deeth with the Maryland Department of Health end Mental Hygiene. Importent: If Item 27 is marked other than "naturel", or iteme 23e or 28e-f eho eny Injury or other treumatic event, it e Madical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 368 Carraca Ct. 21144 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: If Yes, Give White 3 X Widowed 4 Divorced Specify: Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) US Post Office Mail Handler Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Frederick C. Mozingo Arrie B. Mills 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M. Lynn Nelson 368 Carraca Ct Severn, MD 21144 (niece) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 11/26/2012 Glen Burnie, MD 21. Signature of Funeral Service 22. Name and Address of Facility Hardesty Funeral Home 12 Ridgely Ave. Annapolis, MD 21401 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Possible Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Hospital or Attending Physicien: The law requires that the death certificate be executed attending physician end I for use as the buriel-transit 4 resulting in death) Last Due to (or as a consequence of): Physician/Medical OPD Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 1 Yes 2 No been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physicien: The law within 24 hours after death.

To the Funerel Director: After this certificate has t completely filled in by the funeral director, page 2 s performed? 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 El No ၉ 1 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 8c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated MO 0007232f 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARBOR MOSPITAL, BALTIMORE, MD. NORTH CHAVA MEDSTAR

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40696 Reg. No. 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary Theresa Myers 24, 2012 November 6:39 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death
Anne Arundel Anne Arundel Medical Center Annapolis 5. Social Security Number 8. Date of Birth (Month, Day, Year)
Aug. 15, 1 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral 9. Birthplace (State or Foreign Days 217-20-4728 99 Director 1 M 2 X F 1913 Maryland ∠i is marked other then "naturel", or items 23a or 28a-f show
treumatic event, the Medical Examinat must be notified at
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The material of the continuer of the co 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 1705 Virginia Street 21401 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 X No
If Yes, Give <u>ک</u> Black White etc 1 Never Married 2 Married 3altimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: Completed 3 X Widowed 4 Divorced Specify Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry should be filed within 72 hand Mental Hygiene.

Is marked other then "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Cafeteria Worker School System 12 Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Sumame)
 Mary Caroline Cook Otto Hahn ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
283 Hillsmere Drive Annapolis, Maryland 21403 permit. Pege 1 and 2 sh Department of Health ar Importent: If Item 27 is eny injury or other treu Mary Theresa Cisneros/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 12 Burial 2 Cremation 3 Removal from State Glen Haven Mem. Park 11/28/2012 Glen Burnie, Maryland 4 Donation 5 Other (Specify) Signature of Fymeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause op each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Due to (or as a consequence of): disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that the death certificate be executed Cause (Disease or injury ettending physician and for use es the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months: 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records, Completed 1 Yes 2 No 3 Probably 4 Tunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed' 2 No Yes 2 No 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 -10 မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funere 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signa ture and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

NOV 28

Division of Vital

Amend #17,18 per FD State of Maryland / Department of Health and Mental Hygiene AACO Health Dept. 11 F30-12 KAH State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1572 Saint Margarets Road Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 214-26-2623 83 Director 1 □ M 2 🔀 F Nov. 21,1929 Maryland 27 is markad othar than "natural", or itams 23a or 28a-f shov traumatic avant, the Medicel Examiner must be netitibed at 1 and 2 should be filed within 72 hours eftar death with tha Meryland if Haaith end Mental Hygiene. Itsm 27 is markad other than "natural", or itams 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Annapolis 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1572 Saint Margarets Road 21409 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🔀 No Specify: 3 Divorced 4 X Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4 or 5+) Secretary Plastic Textiles Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Henry Novosel Violet Burns Henry Burns Violet Warfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William V. Novosel / Son 341 Dorchester Road Stevensville, MD 21666 or other 20a. Method of Disposition 20b. Place of Disposition (Name of parmit. Pege 1 s
Dapertmant of H
Important: If its
any injury or ot 20c. Location - City or Town, State November 29 1 🕅 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Glen Haven Memorial Park Glen Burnie, MD 2012 21. Signature of Funeral Service Licenses Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy. Severna Park, MD 21146 23a. Part f. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cardiovascular Disease Atheresclerotic Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): To the Mospital or Attanding Physician: The law raquires that the daeth cartificeta be executed within £4 hours after death.

To the Funanti Diractor. After this certificate has been signed by the attending physicien end completely filled in by the funanal diractor, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year Yes 2 ☐ No 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျှ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No ☐ Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 1s Ray a palnemo 29d. Date signed (Month, Day, Year) D005 7465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Battimore MD 21209 NSROJAPAKSEMD 5 203 2835 Smith AV 31. Date filed (Month, Day, Year) State 32. Registrar's Signature NOV 2 8 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 40698 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month POYE JOSEPH THOMAS 9:10A DECEMBER 3 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) March 1, 170-34-8361 69 Director 1 1 M 2 □ F 1943 Pennsylvania Usual Residence of Decedent 28e-f shov 7 is marked other then "natural", or items 23a or 28e-f sho traumatic event, the Modical Exeminer must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Middletown 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4301 Serpentine Road 21769 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?,
1 ☐ Yes 2/2/ANo
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Tooling Machinist and Mental Hygien is marked other t Be 18. Mother's Name (First, Middle, Maiden Sumame)
Justina Shuster 17. Father's Name (First, Middle, Last) 2 Anton Poye 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4301 Serpentine Road, Middletown, MD 21769 permit. Paga 1 and 2 sh Department of Health ar Importent: If item 27 is any Injury or other trau once. Mrs. Joyce Poye, Wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Sacred Heart Cemetery Dec. 7, 2012 Monongahela, PA 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Reenevand of Bastord PA Funeral Home M00255 106 East Church St., Frederick, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Kunel Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: Tha law requires that the death cartificete be exacuted within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and complately filled in by the Inneral director, page 2 should be deteched for use as the burial-transit Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? Day 1 Yes 2 No 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes 2 No Other: ဂ္ဂ 1 DInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Division 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier December 3, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

John sun

32. Registrar's Signature

rederick, MD 21202

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40699 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2012 December 1715 Jerry L. Potter Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil 145 Hollingsworth Manor Elkton If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 220-52-3880 **Director** 1 X M 2 🗆 F 62 July 5, 1950 North Carolina Usual Residence of Deceden : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 X Yes 2 No Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 145 Hollingsworth Manor 21921 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinance. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🗓 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: 3 Widowed 4 X Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed, Elementary/Secondary (0-12) College (1-4 or 5+) 12 Self-employed Carpenter Carpentry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Marvin Potter, Sr. Irene Josephine Main 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dawn Clouthier/Daughter Warwick, MD 21912 15 Frances Drive, 20b. Place of Disposition (Name of cemetery, crematory or other place Gilpin Manor Memorial Park 20a. Method of Disposition 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State December 4 ☐ Donation 5 ☐ Other (Specify) 7, 2012 Elkton, MD 21. Signa re of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Presiden/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions cause (Disease or injury Due to lor as a consuluence of To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death 1 Lyes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown certificate has been signector, page 2 should I Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2X No Yes Be (25. Was case referred to medica 26. Place of Death (Check only one) examiner? n 24 hours after deaun. he Funeral Director: After this cennetely filled in by the funeral dire Hospital မ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 KResidence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

IEKKY LYNN POTTER

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day,

AUGUSTINE

Hwy

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHA HNAWAZ HERMAN

32. Registrary Signature

29d, Date signed (Month,

DOO 62190

SUITE

Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40700 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 11/25/2012 9:02 A M JEAN MILLS PLATOW Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 114 W. CHESTNUT STREET ST. MICHAELS TALBOT Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1170671944 NEW YORK Director 044-40-6764 68 Usual Residence of Decede or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County 10d. Inside City Limits 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 X Yes 2 No MD **TALBOT** ST. MICHAELS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 114 W. CHESTNUT STREET 21663 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 X Married 2 Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify: WHITE Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) PRIVATE RESIDENCE HOMEMAKER permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ ARCHIBALD MACFARLANE JEAN MILLS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) R. ALAN PLATOW/SPOUSE P.O. BOX 888 ST. MICHAELS, MD 21663 ltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20h Place of Disposition (Name of CHite Mark LAKATON GRIMMATE ON 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CENTER 11/26/2012 STEVENSVILLE, MD 21. Signature Live I Service Lic FENTONS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST. EASTON, MD 21601 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final 1 Physician/ disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause Finer Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Physician: The law requires that the death certificate be executed ig physician and as the burial-transit Due to (or as a consequence of) resulting in death) Last been signed by the attending physician should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) g 🗌 Unknown g Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy After this certificate 2 1 ☐ Yes 2 ☐ No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.
Funeral Director: After thi etely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred or Attending 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical 29a Certifier To the Hosp within 24 hou To the Fune completely fi 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) Easton RS/2 32. Redistrar's Signa State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Proctor Sharon 2012 November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Collingswood Nursing & Rehab. Center Rockville Montgomery 5. Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours Director 217-42-3622 69 1 DM 2 X F Yrs Sept. 10, 1943 Washington, DC Usual Residence of Decedent thend Mentel Hygiene. 27 is marked other than "natural", or iteme 23s or 28a-f show traumatic event, the Medical Examinar must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits DC 1 X Yes 2 No Washington ā 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20008 USA 2527 Waterside Drive, NW 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2X No Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify: 3 ☐ Widowed 4 ☑ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) during most of working Elementary/Secondary (0-12) College (3-4 or 5+) Research Administrative Asistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Thomas Clark Julia Mewshaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2527 Waterside Drive, NW, Washington, DC 20008 Kathleen Proctor/Daughter other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Depertment of H
Important: If ite
eny Injury or ott Date 29 Nov. 2012 cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 4 Donation 5 Other (Specify) Alexandria, VA 21. Signatulie of Funeral Service Licensee 22. Name and Address of Facility
|Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the reath. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Advanced Dementia Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physicien end for use es the burial trepsit that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day deteched 9 . Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by or Attending Physician: The law requires Records, icete hes been sig r, pege 2 should b 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?
Yes 2 🖾 No certificete 2 🗌 No 1 Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) B examiner? Hospital Other: 4 🗷 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 Yes 2 🖾 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA this To the Hospitel or Attending Phywithin 24 hours after death.
To the Funeral Director: After this completely filled in by the funeral by 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 1 Natural 2 Accident 5 Pending Division 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of efficie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Box 68760

P.O.

of Vital

M.D

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2012

Rixa Ghosh, MD

31. Date filed (Month, Day, Year)

D30132

14812 Physicians Lane, #161, Rockville, MD 20850

Nov. 28, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Lucille Parker 4a. Facility Name (if not institution, give street and Town, or Location of Death M If Under 24 Hrs. Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, eb 16 O_{M 2}XIF Months Days ^{Year)} 1937 Maryland 214-66-4480 Feb 75

10d. Inside City Limits

10g. Citizen of What Country?

14. Race - American Indian,

Black

Black, White, etc.

USA

Specify:

18. Mother's Name (First, Middle, Maiden Surname)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $2\overline{1401}$ 1103 Smithville St. Apt 225 Annapolis, Md.

atal Dr Glen Byrne Mp

Rachel Della

11-26-12

Miniame Receise of Scilicons Mortuary, P.A.

16b. Kind of Business/Industry

Baldwin Center

20c. Location - City or Town, State

Annapolis, Md.

1 Yes 2 No

10c. City, Town or Location

Memorial

Annapolis

10f. Zip Code

16a. Decedent's Usual Occupation

Housekeeping

21403

(Give kind of work done during most of working life. DO NOT use retired)

1 ☐ Yes 2X No Specify:

Gardens

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

in and Mental Hyglene. 17 is marked other than "natural", or items 23a or 28e-f show traumatic event, the Medicel Examiner must be notified at filed within 72 hours efter death with the Maryland Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filt Department of Health and Mental I Important: If Item 27 is marked c any injury or other traumatic eve once.

Physician/

Medical

Director

Funeral

δ

Completed

Be

Maryland

11 Marital Status

10e. Street and Number

1X Never Married 2 Married

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

Richard Parker 19a. Informant's Name/Relationship (Type, Print)

4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

None

20a. Method of Disposition

10b. County

Anne Arundel

3016 Arundel on the Bay Rd.

15. Decedent's Education (Specify only highest grade completed)

Carrie Belle Jones(Sister)

1 🕅 Burial 2 🗌 Cremation 3 🔲 Removal from State

12. Was Decedent Ever in U.S.

Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates.

College (1-4 or 5+) None

Examiner

Funeral

Director

Physician/ Medical Examiner

> the burial-trar attending physician I for use as the buria cate has been signed by the apage 2 should be detached completely filled in by the funeral director,

To the Hospital or Attending Physician: The law requires that the death certificate be executed

within 24 hours after death.

To the Funeral Director: After this certificate

Division of Vital Records, P.O. Box 68760

	Larry B. S.	eese	1922	Forest	Dr.	Annapo	lis,	Md.	21401	
dical Examined	23a. Part 1. Enter the disease, or complishook, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of)	ck	ode of dying, such a	s cardiac or	respiratory arre	st,		Approximate Interval Between Onset and Death	
I Sicialities	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 NNo 9 Unknown	3c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 Ectopic 5 Other (23d	l. Date of del Month	livery Day Year	7
ica by r	Part II. Other significant conditions con	tributing to death but not resulting in t	the underlying	g cause given in Par	rt I.				the cause of death?	1
and in on						24a. Was ar autops perforr 1 Yes 2	y ned?/	prior to death?	topsy findings available completion of cause of	
2	25. Was case referred to medical examiner?			26. Place of De	eath (Check	only one)				= 1
	1 ☐ Yes 2 No	ospital: 1 Inpatient 2 ER/Outp	atient 3 🗆	DOA Other: 4 🗆 I	Nursing Hon	ne 5 🗆 Reside	nce 6 🗀	Other (Spec	ify)	
icate.	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Tim inju		28c. Injury at work? 1 Yes 2 [8d. Describe ho	w injury oc	curred		
5	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	i, street, facto	ory, office	2	28f. Location (Str City or Town		ımber or Rui	ral Route Number,	
	(Check 2 Medical Examine	cian: To the best of my knowledge, deer: On the basis of examination and/or in Practitioner: To the best of my knowle	nvestigation, i	n my opinion, death	occurred at t	the time, date and	place, and	due to the	cause(s) and manner state	∍d.
	29b. Signature and title of centifier	ua Mn	25	9c. License number	3274	14	Date si	gned (Month	u, Day, Year) W 19 201	16

State Registrar Un

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 12 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ida Beatrice Popowitz 20, 2012 Α November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1190 Monie Road <u>Odenton</u> <u>Anne Arundel County</u> Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In yrs. last birthday) Year If Under 24 Hrs. Days Hours Director 171-18-3545 1 🗆 M 2🏋 F 92 11/06/1920 Pennsylvania aţ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 X Yes 2 🗆 No MD Anne Arundel 0denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? o must be Completed by Funeral 23a 1190 Monie Road 21113 U.S.A. ıral", or items? Examiner mus Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Armed Forces? Black, White, etc. 1 \square Never Married 2 \square Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Specify: White 3 ¥ Widowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 18b. Kind of Business/Industry (Specify only highest grade completed) th and Mental Hygiene.
77 is marked other than traumatic event, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Nurses Aid Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mateo Delfini Giacinta Campana 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 496 West Taylor Run Parkway Alexandria, VA 22314 other t Paul V. Popowitz/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Huntt Crematory Department of Important: If i any injury or c ☐ Burial ② Cremation 3 ☐ Removal from State 11/23/2012 Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Immediate Cause (Final Physicien/ KO disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician hed for use as the buría Physician/Medical or Attending Physician: The law requires that the death certificate be after death. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) detached for in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 9 Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 \square Yes 2 \square Ho 3 \square Probably 4 \square Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 performed 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: ျှ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 4 Nursing Home 5 Residence 6 other (Spec To the Hospital to reconstitution 24 hours after death.

To the Funeral Director: After this remains the funeral principle of the funeral principle of the funeral reconstruction of the f Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending M 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitions: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State

DHMH 17 Rev 06-2011

Registrar

29b. Signature and

0200

12-091	17
Dennis	Palmer

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar		Certificate of	Death		Reg.	No. 2017	2 40/0
Physician/ Medical Examine	1. Decedent's Name (First, Middle	Last) hael Palmer,	Jr.			Date of Death Month Daniel November 36		3. Time of Death 1907 hrs
	4a. Facility Name (if not institution Dorchester General Ho	-		b. City, Town, or Cambridge	Location of Death		4c. County of Death Dorchester	
Funeral Director	579-82-5390		yrs. last birthday) 47 Yrs.	If Under 1 Year Months Days			MM/DD/YYYY) 9. Bir Foreig . 1965 Co	thplace (State or In Washington ^{untry)} DC
and show any ncc.	Usual Residence of Decedent 10a. State 10b. County MD Dorc	nester 10c.	City, Town or Locati		ridge			10d. Inside City Limits 1 Yes 2 No
with the Maryland ms 23s or 28s-f sho he notified at once.		aven Road		10f. Zip Code	21613	10g.	Citizen of What Cour USA	ntry?
fier death	3 Widowed 4 Divo	1 Yes 2 X I	No If Ye	es, specify Cuban Yes 2 χ No	panic Origin? (Sp., Mexican, Puerto specify: ion (Give kind of v	Rican, etc.)	White, etc.	can Indian, Black, White ndustry
2 3 7 7	Elementary/Secondary (0-12)	College (1-4 or 5+) 4	during mo	ost of working life. chef	DO NOT use reti	red)	hotel	
₩ 3	Dennis Michae	el Palmer	Lob Mailia		Milli	cent Ann	- ,	7.70
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Baltimore, ME permit. Pages I and 2 s Department of Health an Important: If item 27 injury or other traum.	20a. Method of Disposition 1 Burial 2 X Cremation 4 Donation 5 Other Spe	3 Removal from State	20b. Place of Disposi crematory or oth Crematory	of Delm	arva 1		Oc.Location-City or Delmar,	
Balt permit Depart Impor injury	21. Signature of Funeral Service L	icensee Www.	22. N 700	ame and Address) Locust	of Facility St., Ca.	omas Fune mbridge,	ral Home MD 21613	P.A.
Physician /Medical xaminer	23a. Part I. Enter the disease, or of failure. List only one cause of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	n each line. a. Hypertensive Due to (or as a consequer b. Due to (or as a consequer c.	e Atheroso					Approximate Interval Between Onset and Death
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on of Vil ending Physic ath. vr. After this he funeral dire	1 Yes 2 No	28a. Date of Injury (Month, Day,Year)	28b. Time of Ir	njury 28c. Injur	Other Nursing Nursing at Work?	g Home 5 Re	sidence 6 Other	:
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To the Hos within 24 h To the Fun completely	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	rsician: To the best of my kno liner: On the basis of examinat and manner stated.						
	29b. Signature and title of certifier	alew).		29c Licens O.C.I			od. Date signed (Mo. December 1, 20	
	30. Name and address of person values and Laron Locke MD. As	ho completed cause of death sistant Medical Examin		ltimore Stree	t, Baltimore, N	MD 21223		
State Registra		32 Registrar's Sig	gnature	the state of the s				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40705 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Marti/18/2012 Physician/ LEONARD RENKENBERGER, JR. 4:10 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death **TALBOT** 8245 INGLETON CIRCLE **EASTON** 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours 1171171934 BEAVER. PA Director 166-26-3270 1 X M 2 □ F **78** Usual Residence of Dece i Hygiene. . other then "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No MD TALBOT **EASTON** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8245 INGLETON CIRCLE USA 21601 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian Armed Force Black, White, etc. 1 Yes 2 No þ 1 Never Married 2 Narried within 72 hours after Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 🕻 No Specify: If Yes. Give 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) DEPARTMENT OF DEFENSE Elementary/Secondary (0-12) College (1-4 or 5+) FACILITIES ENGINEER Be permit. Page 1 and 2 should be filed Department of Health end Mental Hy Important: If item 27 is marked othen yi injury or other treumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ LEONARD RENKENBERGER, SR. MARY EDNA PIERSOL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RUTH R. RENKENBERGER/WIFE 8245 INGLETON CIRCLE EASTON, MD 21601 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Date WHITEMARSH_CEMETERY 11/21/2012 TRAPPE, MD 21. Signature of Funeral Service Licensee FELLOWS Address FENDEIN & NEWNAM FUNERAL HOME, P.A. 200 SOUTH HARRISON ST. EASTON, MD 21601 MERCERO JOHN R. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ cancer ancreati disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the humal-transit Cause (Disease or injuly that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Vear Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?
☐ Yes 2 No 1 ☐ Yes 2 ☒ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 XNo 1 🗌 Yes 욘 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 ANatural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation М 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) November 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2/60/ VAIDYANATHAN 219 S.WASHINGTON ST, EASTON

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month / 25/2012 3:55 PM Robinson Henry Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 74 1 Å M 2 ☐ F Director 363-40-9723 10/27/1938 Michigan permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits Director Temple Hills Maryland Prince George's 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20748 2328 Kirby Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?
1 ☒ Yes 2 ☐ No à 1 Never Married 2 Married Maryland 21215-0036 Black 1 ☐ Yes 2XIX No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced Year or Dates.1965 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Postal Service LSM Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Tda Meadows Rufus Ford Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2328 Kirby Drive Temple Hills, Maryland 20748 Dora Lee Robinson / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial /2 Cremation 3 Removal from State 12/4/2012 4 Donation 5 Other (Specify) Maryland Vet. Cem. Cheltenham, Maryland 21. Signator of Funeral Service Livensee 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Rd. Oxon Hill, Maryland 20745 11 23a. Pg/1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ach line. Approximate Interval Between Onset and Death Weeks Immediate Cause (Final Pnysician/ resulting in death) Medical Due to (or as a consequence of): Examiner RESPIRATORY FAILURE weeks Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine PNEUMONIA weeks The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death signed by the and be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ End Stage Renal Disease 1 Yes 2 No 3 Probably 4X Unknown Completed Diabetes Mellitus Type 2 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has funeral director, page 2 1 Yes 2 No 2 X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 🗓 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 은 1xxInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 🛛 Natural 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of co 29c. License number 29d, Date signed (Month, Day, Year) MZ D32332 11/25/2012

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DHMH 17 Rev 06-2011

Registrar

9801 Georgia Avenue #220 Silver

Registrar's Signature

Spring, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suresh Gupta MD

NOV28

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Swarey 8:00A Susie 2012 November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charles 9033 Glock Place Charlotte Hall If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours (Month, Day, Year) 215-56-7341 **Director** 91 01/12/1921 Pennsylvania Usual Residence of Decede 28a-f show 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10d. Inside City Limits rector 1 🗌 Yes 2 🕱 No Charlotte Hall Charles Maryland 靣 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 20622 9033 Glock Place Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry سالا be filed with... عال Hygiene. عال بعد than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker d 2 should be filed withi alth and Mental Hygiens 127 is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ **Stoltzfus** Lydia Benjamin Sto1tzfus traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If item 27 is any injury or Attack Ben Swarey/Son 9140 Farmland Place, Charlotte Hall, MD 20622 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Fisher Cemetery 11/28/2012 Mechanicsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21 Sign Jure of Funeral Service Lie Martingley-Gardiner Funeral Home, P.A. 41590 Fenwick St., Leonardtown, MD 20650 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDISPULMONARY Ph_sician/ ARRES Medical resulting in death) **Examiner** HUPERTEN Sequentially list conditions, Examine cause. Enter Underlying burial-transif Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 2 No 1 Yes Yes 2 No ospital or Attending Physician: hours after death. filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 \sum Nursing Home 5 \sum Residence 6 \sum Other (Specify) ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Director; After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State

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Medical

29a, Certifier

29b. Signature and title of cortifier

wow my

FEDERICO

Hospital within 24 hours a

> 31. Date filed (Month, Day, Year) 32. Registrar's Signature

GEORGE

Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

27/

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Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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			For State	State of I	Marylan		artment d tificate d			and M		/	2012	2 !	4070	8
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in man	Medic Examir		4a. Facility Name (if not institution	n, give street and number	r)		4b. City, Tow	vn, or Lo	ocation o				ounty of Dea			
-	/		Charlotte Hall				Char						t. Ma			_
	Funeral Director		5. Social Security Number 244-52-4694	6. Sex 1 X M 2 □ F	Age (In yrs. k	ast birthday) Yrs.	If Under 1 Y Months D		Hours 1	Min.	8. Date of Birt (Month, Day 08/26/1	v. Year)	Co	ountry)	State or Foreig	n
			Usual Residence of Decedent								7072071		1. 08			_
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Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 X Cremation	3 ☐ Removal from Str	ate c	emetery, cren	sition (Name on natory or other	r place)			ate	20c. Loca	ation - City o	r Town,	State	
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P.O.	that the dea		Part II. Other significant condition	ons contributing to deat	h but not res	ulting in the u	nderlying caus	se given	n in Part I.		23e. Did to	obacco use	contribute t	o the ca	use of death?	
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Division of Vital Records,	al or A s after I Direct d in by		4 ☐ Homicide detern		etc. (Specify		set, lactory, on	IIC e			City or Tow		vurriger or At	irai nou	te Number,	
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	7 × 7 0		> Xallin	West						20			2 / Zo		. July	
	,		30. Name and address of person	who completed cause of	f death (Item	23a) (Type: F		05	720	-6 M	nD	1616	-100	, _		_
)4	-1 reme		Stephen Caffert	y, M.D., 29	9449 C	harlot	*	1 Rd	d., (Charl	otte H	a11,	MD_206	522		
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DHMH 17 Rev 7/2009

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		P	State of M. State	T.7 N.4. CO.	epartment of I Certificate of I			iene 2012	40709
	Physicia Medic		1. Decedent's Name (First, Middle, Last) MARGARET M	SP	ILLANE	-	2. Date of Deat		3. Time of Death
200	Examin		4a. Facility Name (if not institution, give street and number)			or Location of Death		4c. County of Dea	ath
	Funeral		Sanctuary at Holy Cross 5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birtho		nsville I If Under 24 Hrs.	8. Date of Birth	Montgon 9. Bi	nery rthplace (State or Foreign
	Funeral Director		170-10-9683 1 □ M 2 🕱 F	101 Yr	Months Days	Hours Min.	07/05/1	911 Per	nnsylvania
	how at	ž	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	or_Location				10d. Inside City Limits
	larylar 8a-f sl tified	Director	10a. State PA Lackawanna Maryland Montgomery	10c. City, Town of Archba -Caithe	ıld roburz -				1 🕅 Yes 2 🚟 No
	a or 2 be no		10e Street and Number 219 S. Main Street 19627 Sparr Spring Road		10f. Zip Code	103		10g. Citizen of What C	ountry?
	th with ms 23 must	Funeral		IIO I	-2088	36 -	anife Man on No	United S	
Maryland 21215-0036	e filed within 72 hours after death with the Maryland ttal Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at.	þ	11. Marital Status 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent If Armed Forces? 1 ☐ Yes, Give Year or Dates.		13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	an, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify:	
5-0	2 hou "natu edical	plet	15. Decedent's Education (Specify only highest grade completed)	1 (0	ecedent's Usual Occu Give kind of work done	during most of worl	king	16b. Kind of Business	s Industry
121	ed within 7 Hygiene. other than ent, the M	Completed	Elementary/Seconday (0-12) College (1-4 or 5	5+) · lit	fe. DO NOT use retired Teacher)		Educati	on
pu 2	filed wall Hyg		17. Father's Name (First, Middle, Last)		- 40	18. Mother's Nan	ne (First, Middle, N	Maiden Surname)	
ylaı	should be file h and Mental I 7 is marked o raumatic eve	ျ	Thomas Spillane				Ellen_	P. Corco	ran
Mar	2 shouth and the and the strain traum		19a. Informant's Name/Relationship (Type, Print) William Regen/Nephew		Mailing Address (Street			-	
	of and 2 should be of Health and Ment fitem 27 is marked rother traumatic e		20a. Method of Disposition	20b. Place of D	27 Sparr S Disposition (Name of		Date Galli	20c. Location - City o	
imo	Page ment c ant: If ury or		1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		mas Aquina		9/2012	Archbald,	PA.
Baltimore,	permit. Page 1 a Department of B Important; If it any injury or of once.		21. Signature of Funeral Service Licenses		22. Name and Address 10 East De	ess of Facility ${ m DeV}$	ol Funer		MD. 20877
			23a. Part Enter the disease, or complications that caused shock or heart failure. List only one cause on each line	d the death. Do not	t enter the mode of dyi	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Medical	i la	Immediate Cause (Final disease or condition resulting in death)	BILLA	-	ANCER			Onset and Death
-	Examiner		Due to (or as	a consequence of)					
	_ +	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a consequence of)					
	and -transi	Examine	Cause (Disease or linjury that initiated events c.	a consequence of)	:	_			
0	death certificate be executed re attending physician and ed for use as the burial-transit	edical E	d d						
3760	ificate ig phy: as the	Medi	IF FEMALE:						
Box 687	th cert tendin or use	ian/I	23b. Was decedent pregnant 23c. If yes, outcome 1 Live Birth	2 Fetal death	3 Ectopic pregnar	псу		23d. Date of d	elivery Day Y ear
		Physician/M	1	it time of death	5 ☐ Other (specify) _			Worter	Day Teal
s, P.O.	The law requires that the death certific atte has been signed by the attending page 2 should be detached for use as	Completed by Ph	Part II: Other significant conditions contributing to death b	out not resulting in	the underlying cause g	iven in Part I.		bacco use contribute t	to the cause of death? Probably 4 Donknown
ord	v requi	olete					24a. Was a		utopsy findings available
Rec	sician: The law certificate has b lirector, page 2 s	Som					autops perfor 1 Yes	med? death?	
tal	cian:	Be	25. Was case referred to medical examiner?			Place of Death hea			
Je Vi	Physi rthis o	일.	1 ☐ Yes 2 ☐ No 1 ☐ Inpati 27. Manner of Death 28a. Date of inju	ient 2 ER/Outp	oatient 3 L DOA	4 Mursing H		ence 6 Other (Spe	cify)
o uc	ath. r: Afte	icate	1 Natural 5 Pending (Month, Da 2 Accident Investigation	y, Year) inju	ury wor	rk? ☐ Yes 2 ☐ No		,.,	
Division of Vital Records,	Hospital or Attending Physician: 44 hours after death. Funeral Director After this certificated filled in by the funeral director,	Certificate:	3 Suicide 6 Could not be	ury - At home, farm c. (Specify)	n, street, factory, office		28f. Location (St City or Town	reet and Number or R. n, State)	ural Route Number,
	To the Hospital or Attending Physician: "In thin 24 hours after death as a feet death. To the Funeral Director After this certific completed filled in by the funeral director."	Medical	29a. Certifier 1 Certifying Physician: To the best of (Check 2 Medical Examiner: On the basis of e only one) 3 Certifying Nurse Practioner: To the	examination and/or i	investigation, in my opin	ion, death occurred	at the time, date ar	nd place, and due to the	e cause(s) and manner stated.
	To the To the Comp	-	29b. Signature and title of certifier	,	29c. Licens		-	29d. Date signed (Mon	
	15		Jasepen Vall	aui'	nui) Di	28595		11/26/12	
			30 Name and address of person who completed cause of completed cause of CALLHAN	11, m)	pe, Prist) Bo	y 1525	- Ow	INGS MI	e rus 2117
	Sta Registr		31. Date filed (Month, Day, Year) 82. Registr.	ar's Śign ture	arked.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Patricia Helen Sisler November 23. 2012 7:00A. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Silver Spring 4c. County of Death
Montgomery Examiner Holy Cross Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Numbe 291-20-5759 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Nov.1,1927 Days Hours 85 OHTO Director 1 □ M 2 🕅 F item 27 is rarked other than "natural", or items 23a or 28a-f shov other trans atte event, the Medical Examiner must be notified at. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Direct Prince George's Beltsville Maryland 1 ☐ Yes 2X No 10f. Zip Code 10g. Citizen of What Country? Funeral 11004 Emack Road 20705 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. ξ 1 Never Married 2 M Married altimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: and Mental Hygiene. Is marked other than "natural", If Yes, Give 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4-or 5+) Elementary/Secondary (0-12) Librarian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Nina Buell Francis Smith permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is a rake any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5400 Vantage Point Road, HC nn.#422 Columbia, Maryland 21.044 Hugh Sisler -husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cometery creative or other place)
Everymen — South
Southside Cemetery 1 Bunal 2 Cremation 3 Removal from State 11/30/2012 Johnston Township, Ohio 4 Donation 5 Other (Specify) Signature of Funeral Service Lice Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Respiratory Failure Medical Due to (or as a consequence of) Examiner Exacerbation COPD Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director. Lung Aspergillosis that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Atrial Flutter 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Gastric Ucler 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy ormed? 2 🔯 No 1 ☐ Yes 2 🖾 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗓 No မှ 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No ☐ Acciden Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifle 29c. License number 29d. Date signed (Month, Day, Year) hmanian CU November 26, 2012 D66372 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Majid Rahmanian, M.D. HCH 1500 Forest Glen Road Silver Spring, Maryland 20910 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 28 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 | 2 State Registrar Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Reynold J. Schnyder, Jr. November 2012 рм 7:21 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) Days 564-82-6302 **Director** 1 🖾 M 2 🗆 F 79 Oct. 6, 1933 LA Usual Residence of Decedent r than "neturel", or items 23e or 28e-f show the Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after deeth with the Maryland 10d. Inside City Limits Director 1 ☐ Yes 2 🙀 No MD P.G. Greenbelt 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7200 Mathew Street 20770 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 X Never Married 2 Married Maryland 21215-0036 Black 1 ☐ Yes 2 A No Specify: Completed 3 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Depertment of Health and Mental Hygiene. Important: If Item 27 Is merked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Reynold J. Schnyder, Sr. Lue Bell James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2121 Clouet Street, New Orleans, LA 70117 Clayton P. Schnyder, Sr/Brother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Nov. 27 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Injury or Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 2012 21. Signature of Funeral Service Licenson 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. MD 20901 W., Silver Spring. 231 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) myocardial Infarction Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) ettending physicien end I for use as the burial-transit Hospitel or Attending Physician: The lew requires that the death certificate be executed Cause (Disease of Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Pregnant at time of death cate has been signed by the e page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 2 1No 1 🗌 Yes Yes 2 No To the Hospitel or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice completely filled in by the funeral director. 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) ည 1 🗌 Yes 2 🗗 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 Accident
3 Suicide 2 🗌 No Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11/26/12 72207 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Park, MD 20912 Ansaldo 7400 Takoma Carroll Ave 31. Date filed (Month, Day, Year) 62. Registrar's Signature State

Registrar

NOV 28 2012

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 1 - State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nov. 18, Day 2012 Year 1:08pDiana Marie Stewart Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring Holy Cross Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) **Funeral** 217-92-9699 Director 1 □ M 2 🗓 F 46 Nov.18, 1966 Pennsylvania Usual Residence of De ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 🗆 Yes 2 🛣 No Montgomery Silver Spring MD 10f. Zip Code 10g. Citizen of What Country? Funeral 20902 USA 10921 Inwood Avenue Apt. #111 permit. Page 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mental Hygiene.} Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Give kind of work done life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Unknown Unknown Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Diana Wilson Joseph James Stewart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 111 S. Mt. Airy Ave., Egg Harbor Twnshp, NJ 08234 Joseph C. Stewart/Brother 20a. Method of Disposition
1 ☐ Burlal 2 🛣 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Metro Crematory Nov.20,2012 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fu anal Service in sec 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD 20715 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Mechanical Ventilation Failure Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Spina Bifida Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence oi): Quadriplegia and Il-trans that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Vent Dependency Physician/Medical þ 68760 law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 A No Unknown g Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Acidosis 1 □ Yes 2 X No 3 □ Probably 4 □ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy Hospital or Attending Physician: The 2 🗌 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? X 1 ☐ Yes 2 H No Hospital 1 Inpatient 2 I ER/Outpatient 3 X DOA Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral C completely filled 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, 12 19 S. Naa D0056936 6502 Kenilworth\S#100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Riverdale Park, MD 20737 SHERENE NAGARAJA 31. Date filed (Month, Day, Year) 32 Registrar's Signature NOV 27 2012

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2<u>5</u> Physician/ Month November 10:55# Eleanor Sherwin 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Heritage Harbour

5. Social Security Number | 6. Sex Annapolis
If Under 1 Year | If Under 24 Hrs. Anne Arunde1 8. Date of Birth (Month, Day, Aug. 5 Funeral 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days Hours 204-07-0964 Country) Director 1 □ M 2 🖾 F 92 PA. 1920 Aug. Usual Residence of Decede er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No Annapolis Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 84 Old Mill Bottom Road N 21409 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? 1 ☐ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 White 1 ☐ Yes 2 🖾 No Specify. If Yes Give 3 Nidowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Secon 12th ondary (0-12) College (1-4 or 5+) Own Home Homemaker Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked out any lioury or other traumatic even any lioury or other traumatic even 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Fallon George Wetton ^{19a.} Informant's Name/Relationship *(Type, Print)* Records of Sweeny Funeral Home 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Codil 9073 209 N. Newton Street Rd. Newtown Square, PA Baltimore, 20b. Place of Disposition (Name of Scennstery, cremators or other place Cemeter). 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 30 2**0**12 Broomall, PA. 4 ☐ Donation 5 ☐ Other (Specify) Nov. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Reese & Sons Mortuary, Dr. Annapolis, P.A. Md. 21401 23a. Part 1. Enter the disease, or complications that caused the d. th. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a cons or ence of Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or). or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death ate has been signed by the a page 2 should be detached to Yes 2 No 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy After this certificate has 1 Yes 2 No I ☐ Yes ours after death.

eral Director After this certifica filled in by the funeral director, i 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Hospital 2 110 Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No М Investigation 6 Could not b Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital of within 24 hours a To the Funeral D Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Conflying Nurse Practitioner: To the best of my knowledge, death occurred at the time, deterand place, and due to the resistion and memor as stated 29b. Signature and title of certifie

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

11/2	nd #8 per 29/12 AA	œ.	Dept State of Maryland / Den	ndelible Ink. Ensure All Copies Are Legible. artment of Health and Mental Hygiene
Hea.	lth 1	0 .	101	rtificate of Death Reg. No. 2012 L071L
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Samuel George Steinour	2. Date of Death Month Day Year November 21, 2012 6:55 A M
0	Examin	er	4a Facility Name (if not institution, give street and number) Calvert County Nursing Center	4b. City, Town, or Location of Death Prince Frederick 4c. County of Death Calvert
	Funeral Director		5. Social Security Number 578-26-2721 6. Sex 7. Age (In yrs. last birthday) 1X□ M 2 □ F 88 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min. August 19/24 9. Birthplace (State or Foreign Country) Penns v I vania
	yland -f show ed at	ctor	Usual Residence of Decedent	ocation 10d. Inside City Limits
	eath with the Maryland tems 23a or 28a-f show er must be notified at	≧.	Maryland Calvert Prince F1 10e. Street and Number 114 Terrace Drive	10f. Zip Code 10g. Citizen of What Country? 10f. S. A. 1 U. S. A.
		Funer	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Specify Yes or No-
9036	2 hours after death with "natural", or items 23 adical Examiner must	þ	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 No If Yes, Give Year or Dates. 1943–46	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Specify: White
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4 or 5+)	dent's Usual Occupation kind of work done during most of working O NOT use retired) U.S. Government
		To Be	17. Father's Name (First, Middle, Last) George William Steinour	18. Mother's Name (First, Middle, Maiden Surname) Lettie Estelle Warner
				ng Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gernace Drive, Prince Frederick MD 20678
Baltimore,	ge 1 and nt of Hea : If item or other		20a. Method of Disposition 1 Disposition 20b. Place of Disposition 20b. Place of Disposition 3 ☐ Removal from State	osition (Name of Date 20c. Location - City or Town, State
altin	ermit. Pa epartmer nportant ny injury			oln Cemetery 11/27/2012 Brentwood, MD 2. Name and Address of Facility Robert E. Evans Funeral Home
Ш	Physician/ Medical		23a, Part 1. Enter the disease, or complications that caused the death. Do not en	16000 Annapolis Road, Bowie, Maryland 20715 er the mode of dying, such as cardiac or respiratory arrest, Approximate
C			shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):	~5·/• ^
	xecuted n and al-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):	idenia
P.O. Box 68760	res that the death certificate be ex signed by the attending physician d be detached for use as the buria	dical	d	
		by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Pregnant at time of death 5 ☐ Pregnant at time of death 5 ☐ Unknown	Ectopic pregnancy Other (specify) 23d. Date of delivery Month Day Year
	requires that the been signed by the should be detach	by Phy	Part II. Other significant conditions contributing to death but not resulting in the	, 0
ords,	requi been shoul	Completed		1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available
Rec	: The law cate has r, page 2			autopsy prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No
Division of Vital Records,	ysician s certifi directol		25. Was case referred to pedical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)
	ding Phys h. After this funeral di		27. Manner of Death 1 Natural 5 □ Pending 28a. Date of injury (Month, Day, Year) injury	
			"2	
	e nospital or 124 hours afte e Funeral Dir letely filled in		29a. Certifier (Check (Check only one) 3 Certifying Physician: To the best of my knowledge, death only one) 3 Certifying Nurse Practitioner: To the best of my knowledge.	occurred at the time, date and place, and due to the cause(s) and manner as stated. tigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	To the within 2 To the Comple		29b. Signature and title of contingr	29c. License number 29d. Date signed (Month, Day, Year)
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Managi Matheura MD 110 Hagnital Poad Suite#205 Deinog Franchisk MD 20679			
1	Manoj Mathur, MD 110 Hospital Road Suite#305 Prince Frederick, MD 20678 State 31. Date filed (Month, Day, Year) 100 2 7 2012			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SHERDEL Physician/ Month 1450 VE NNE UH Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Mandrin Hospice House Harwood Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Yea **Funeral** Birthplace (State or Foreign Country) Months Days Hours 051-16-0992 **Director** 91 **X**XM 2 □ F May 22, 1921 New York th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Maryland Edgewater 1 ☐ Yes 2 🔀 No 10e. Street and Number 10g. Citizen of What Country? U.S.A. 10f. Zip Code 8 Air Park Drive Funeral 21037 12. Was Decedent Ever in U.S. Armed Forces? ₩X Yes 2 □ No If Yes, Give Year or Dates. 1943–45 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Owner Paper Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be file and Mental F. Frederick Sherdel Leonora Del Gado 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Janet E. Coughlin/daughter 5 Park Place, Unit 315 Annapolis, Maryland 21401 and 2 s Health tem 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If its
any injury or ot 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore Crematory 11/27/2012 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition nset and Death Physician/ ORONARG ISEASE Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician. The law requires that the death certificate be see Pubras after death.
 Pubraral Director: After this certificate has been signed by the attending physicial eletay filled in by the furneral director, page 2 should be detached for use as the burnieletay filled in by the furneral director, page 2 should be detached for use as the burnieletay. 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by NEU MONI A 1 Yes 2 No 3 Probably 4 Inknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 🗆 No **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) , NO i examiner? Other: 4 Nursing Home 5 Residence MANDIGIT 2 No ၉ CARELTR 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending ☐ Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, ANNAPOLIS MD 21401 mD 31. Date filed (Month, Day, Year) 32. Redistrar's Signature Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 2900 Shipmaster Way #314 Annapolis 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 83 528-32-9084 Director 1 XM 2 □ F Nov. 3. 1929 items 23a or 28a-f show 10d. Inside City Limits within 72 hours after death with the Maryland 10b County 10c. City, Town or Location Director 1 Yes 2 No Palm Beach West Palm Beach 10e. Street and Numbe 10f. Zip Code 10q. Citizen of What Country? Funeral 33417 233 Dorchester J Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 1. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married 27 is marked other than "natural", or traumatic event, the Medical Examination δ Yes 2 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 😾 No Year or Dates. Korea Specify: White 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Attorney Patent 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Milisent Painter Norman E. Sears 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Mckendree Ave. Annapolis, MD 21401 Christopher Sears (son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 11/26/2012 Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and ed by the attending physician and detached for use as the burial-transif Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detac. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 1 ☐ Yes 2 ☐ No **Division of Vital** filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2. No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of Certificate: 1 Natural 28c. Injury at 5 Pending 1 Yes 2 🗌 No Accident Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of pertifier Made d cause of death (Item 23a) (Type, Print) ICHAEL State 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Claude Stripling 10:00 a M 2012 -Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Riderwood Village Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last hirthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Days 429-12-5494 **Director** 1 🕅 M 2 🗆 F 91 12-9-1920 AK Usual Residence of Deceden 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2 No MD Montgomery Silver Spring 10e. Street and Number ò 10g. Citizen of What Country? ıral", or items 23a or Examiner must be r Funeral 3200 Gracefield Road Apt. CT411 20909 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Yes : Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2X No Specify: "natural", Completed 3 Widowed 4 Divorced Specify: White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry Social Security Administration (Specify only highest grade completed) if Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Civil Service Investigator Elementary/Secondary (0-12) College (1-4 or 5+) Businessman/Appraiser Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Nettie Cureton Stripling Claude W. Stripling 19a. Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code)
3200 Greenfield Rd. Apt. CT411
Silver Spring, MD 20909 Theresa Stripling / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or otl once. 20c. Location - City or Town, State 27 November 1 Burial 2 K Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory INC. 2012 Baltimore, MD 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home
495 Ritchie Hwy. Severna Park, MD 21146 21. Signature of Funeral Service Licensee 23a. Part f. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear feiture. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ MUELOGEWOUS LEVERMIN HWIE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death Month Year the 1 ☐ Yes 2 ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by . 24 hours after death.

• Funeral Director: After this certificate has been signed intended in by the funeral director, page 2 should t 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Hospital or Attending Physician: The 1 🗆 Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 🛂 No 1 Tes Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation 3 Sulcide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town. State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Thurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the within 2. 29b. Signatur**ş** 29d. Date signed (Month, Day, Year) 11/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar ESMAIHAD MI

31. Date filed (Month, Day, Year)

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NOV 28 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day}2012 Physician/ Nov. 25 Andrew Grant 13:34P M Taylor Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 8 Date of Birth **Funeral** 7. Age (In vrs. last birthday) (Month, Day, Year Nov • 11 , 1 Days 220-40-4325 Director 1 🕅 M 2 🗆 F 68 1944 Maryland Usual Residence of Deceden ral", or items 23a or 28a-f shov Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🕅 No Damascus Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 24837 Showbarn Circle 20872 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White "natural", 3 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. Orthodonic Elementary/Secondary (0-12) College (1-4 or 5+) Laboratory Owner/Operator Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked othery injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ഉ Burliss Taylor Jeanette Burke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan R. Taylor - Wife 24837 Showbarn Circle, Damascus, Maryland 20872 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Wesley Grove Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 11/30/12 Gaithersburg, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility
Molesworth-Williams P.A., Fur
26401 Ridge Road, Damascus, Funeral Home Welliam overt L. 20872 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Seosis disease or condition resulting in death) Medical Due to for a a consequence of: Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine attending physician and I for use as the burial-transit Acute that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Month Day Pregnant at time of death ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Ū No م 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Box 68760 P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach. Records, **Division of Vital**

DHMH 17 Rev 06-2011

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Registrar

State

29b. Signature and title of certifier

31. Date file (Month, Day, Year)

Pine

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9901

28 2012

32. He istrar's Signature

Green

MO

NOV

2 Gentlying Nurse Prantitioner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Prantitioner To the best of my knowledge, death continued at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 66940

Medical Center Drive Rockville, ND 20850

29d. Date signed (Month, Day, Year)

12-09127 Tazanu Ferdinand

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 40719

		1- For State Registrar			Certific	ate of	Death			Re	g. No.		
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last)									n Day	Year	3. Time of Death
wedicai Examii	ıer	Ferdinand 4a. Facility Name (if not institution		Tazar	ıu	14	o. City, Town, or	r Location o		December	1, 2012	unty of Death	0645 hrs
Summer		3216 Toledo Place #2	-	umber)		"	Hyattsville	Location	n Death			ce George	
Funeral		5. Social Security Number	6. Sex	7. Age (In y	rs. last bir	thday)	If Under 1 Yes			B. Date of Birt	h (MM/DD/		thplace (State or
Director		219-73-4489	1XM 2 F	3	4	Yrs.	Months Day	/s Hours	Min.	9/03/	1978	Foreig Co	n untnCameroon
b		Usual Residence of Decedent 10a. State 10b. County		lan- i									
ow any			ce Georg			or Locatio	" sville						10d. Inside City Limits 1 Yes 2 No
uylanc in-f sh	cţo	10e. Street and Number		, ,		T	10f. Zip Code			110	a Citizen	of What Cour	
th the Maryland 23a or 28a-f sho notified at once.	Director	3216 Toledo	Place #	203			207	82		. [-	USA	
with 1		11. Marital Status		cedent Ever i	n U.S.		Decedent of Hi						can Indian, Black,
death or ite	Funeral	1 Never Married 2 N	1Yes	2 X N	0	If Ye	s, specify Cuba	n, Mexican,	Puerto Ric	an, etc.)		White, etc.	_
s after	ھ	3 Widowed 4 Div 15. Decedent's Education (Spe	vorced If Yes, Give Ye		n Tag-		res 2 X No		T		Spe		ack
2 hour	ge d	Elementary/Secondary (0-12)		1-4 or 5+)	1) Ioa.	during mo	s Usual Occupa st of working life	DO NOT	use retired	(aone	16b. Kina	of Business/I	ndustry
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Completed	12 Driver								Transp			rtation
215-0(be filed wintal Hygier rked other ent, the M		17. Father's Name (First, Middle							,	rst, Middle, M		name)	· · · · · · · · · · · · · · · · · · ·
21215-00; uld be filed with Mental Hygiene marked other ti e event, the Mes	To Be	Joseph Tanga 19a. Informant's Name/Relations	-		110	h Mailina	Address (Stree		ggi	Nkafı		T. 01.1	
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once		Julius A.Fom		other									Md.20705
구 경금 불류		20a. Method of Disposition		20	Ob. Place		on (Name of ce			ate		tion - City or	
MOFG Pages 1 ent of Fi		1 Burial 2 Cremation 4 Donation 5 Other S	. —	rom State		-	. ,	ry	1/18/	/2013	Font	tem.C	ameroon
Baltimore, permit. Pages I ar Department of Hee Important: If ite	-1	21. Si na re of Funeral Se	icensee										
- 204.		weg I'm	uft			92	41 Col	umbi	a Bl	vd.Si	lver	Spri	CE,PA ng,Md2091
Physician // // // // // // // // // // // // //		23a. Part I. Ent of the disease, or failure. List only one cause	on each line.									or heart	Approximate Interval Between Onset and
Examiner	- 1	Immediate Cause (Final disease or condition resulting in death)	a.Cardion Due to (or as a			left	ventri	cular	hype	rtroph	ıy		Death
man of the second	.	Sequentially list conditions,	b										
	Examiner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a	a consequenc	ce of):								
_ /_	хап	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	a consequenc	e of):								
m and li - trans			d	#1	atad	222	pt.II,2	7		025 1	0 12		
2.2.2	/Medical	X UNPENDED				, 23a ,	PL-11,2	/,per	me,g	935 1-			
3 - LA	2	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	ne 23c. If yes,	outcome of p birth	regnancy 2	Feta	I death 3	Ectopic	pregnancy	,	23d. Da Mon	ate of delivery oth D	v Day Year
Box 68 death certif	Sici			nant at time o	f death	=	r (Specify)						
cords, P.O. Box 68 law requires that the death certif has been signed by the attending 2 should be detached for use as	Completed by Physician	Part II. Other significant condit	9 Unkn		ot resulting	a in the un	derlying cause	given in Par	rt I	23e. Did tot	pacco use o	contribute to	the cause of death?
P.C es that igned	ē	Bridging of 1								ı			pably 4 🗹 Unknown
rds, requir been s	eţe						-	-	, j)	24a. Was a		4b. Were au	topsy findings available
eco he law tte has										autops perforr 1 ✔ Yes 2	ned?	death?	completion of cause of
Ertificator, pa	Be	25. Was case referred to medica					26.Place	of Death (Check only			1 ✓ Ye	s 2 No
Viting of the control	의	examiner? 1 ✔ Yes 2 No	Hospital: 1	Inpatient 2		utpatient		Other ₄	Nursing H	ome 5 🗌 F	Residence	6 🗸 Other	: Scene
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death. In Director: After this certificate has been signed by the funeral director, page 2 should be detactly to the funeral director, page 2 should be detactly		27. Manner of Death 1 X Natural 5 Pend		of Injury n, Day,Year)	28b.	Time of Inj		ry at Work		d. Describe h	ow injury o	ccurred	
SiO	g	2 Accident Inves	stigation	a of lating /	t home fo		factory, office b	Yes 2					
Div	Certification:		d not be (Specify)		at rionne, re	iiii, sireet,	ractory, office t	Juliuling, etc	. 201	or Town, St		umper or Ru	ral Route Number, City
Hospi 24 hou Funca	_	29a Certifier	hysician: To the be:	st of my know	ledge, dea	ath occurre	d at the time, d	ate and pla	ce, and due	to the cause	(s) and ma	anner as state	ed.
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funcral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical		miner: On the basis and manner s	of examination	n and/or i	nvestigatio	n, in my opinior	n, death occ	curred at the	e time, date a	nd place, a	and due to the	e cause(s)
3-PE4	≨	29b. Signature and title of certifie	er				29c, Licens						nth, Day, Year)
		unesc					O.C.	M. ± .			Decem	ber 2, 201	2
		 Name and address of person Ana Rubio M.D., Ph. I 			,	900 V	V. Baltimore	Street	Baltimor	e. MD 212	223		
Sta		31. Date filed (Month, Day, Year)	32.70	egistrar's Sigr	nature	park	1						
Regist	аг	DEC 07	2012 Le	was	P. 1	9	NT NO.	_					

. por 2-		s # 1, 24a,25,26 Plea	se Type or Print in State of Maryl				-			1.0720
_		1 State Registrar 1. Decedent's Name (First, Middle	ie. Last)		Certificate of	Death	2. Date of De	Reg. No.	012	4 0 7 2 (
Physic /Medi		Vivo	1 Vakit	Viva	ın Vaky		Month	22 2	6/2 C	1:30p M
Exami		4a. Facility Name (If not institution	is copal like	arec	omm. n	r Location of Death.	Will	e P	nty of Death	
Funeral Director		5. Social Security Number 465-38-0268 Usual Residence of Decedent	6. Sex 7. Age (In.) 1 1 1	yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D 09/13/	1925	9. Birthpla Country Texas	ce (State or Foreign y)
Maryland a-f show	ctor	10a. State 10b. County		. City, Town o	r Location				100	d. Inside City Limits 1 □Yes 2X No
vith the	Funeral Director	10e. Street and Number			10f. Zip Code				of What Country	y?
ns 23a	neral	10450 Lottsfor	d Road, Apt. 25		20721 13. Was Decedent of H	Hispanic Origin? (Sp	ecify Yes or N	U. S	A. A. lace - American	n Indian,
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, its Medical Eval, that could be notified at once.	d by Fur	1 ☐ Never Married 2 💢 Man 3 ☐ Widowed 4 ☐ Divorced	I IT YAS GIVA		13. Was Decedent of H If Yes, specify Cuba 1 □Yes 2 🏋 No	an, Mexican, Puerto	Rican, etc.)		alack, White, etc	
Mal ylatio ZIZI3-0030 d 2 should be filed within 72 hours aft th and Mental Hygiene. ZY is marked other than "natural", or traumatic event, in Medical Even.	Completed by	(Specify only highe	t's Education st grade completed)	16a. D	ecedent's Usual Occup Give kind of work done of fe. DO NOT use retired	oation during most of work	ing	7	Business/Indu Departn	
d withi giene. er than	Jmo.	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		eign Servi			of Sta		iieii c
be file ital Hy d othe event,	Be	17. Father's Name (First, Middle,	Last)		-	18. Mother's Name		•	ame)	
thould he marke	은	Peter Vaky 19a. Informant's Name/Relations	hin (Type Print)	19b M	lailing Address (Street	Arsinoy	<u> </u>		vn. State. Zin C	Cade)
ind 2 saith ar		Luann Colburn V		- 1	50 Lottsfo					
rmit. Pages 1 ar partment of Hea portant; If item : y Injury or other	1 8	20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation	3 ☐ Removal from State	Db. Place of D cemetery,	isposition (Name of crematory or other place	ce)	Date	20c. Locatio	n - City or Tow	n, State
t. Pages rtment of lartment; If ite		4 ☐ Donation 5 ☐ Other (S	pecify)	luntt (rematory			Waldor		
permi Depai Impor any Ir		21. Signature of Funeral Service	Licensee		22. Name and Addre					
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	only one cause on each line. a. Due to (or as a con	MM) sequence of)	in	ng, such as cardiac	or respiratory	arrest,	i i	Approximate nterval Between Onset and Death
eath certificate be executed attending physician and for use as the burial-transit	dical Examiner	ause. Enter Underlying Cause (Disease or njury that initiated events resulting in death) Last	c. Due to (or as a conduction of d.	usequence of)	<i>w</i>					
by the attending ached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	y		1	Date of delivery Month D	y Oay Year
quires that the de n signed by the ald be detached i	ğ	Part II. Other significant condition	ons contributing to death but not	resulting in th	ne underlying cause giv	en in Part I.				cause of death?
Hospital or Attending Physician: The law requires that the death certificate be egy hours after death. Funeral Director: After this certificate has been signed by the attending physician tell filled in by the funeral director, page 2 should be detached for use as the burit	Completed						perf	s an 24 ppsy formed? 2 \$\frac{1}{2}No	b. Were autops prior to comp death? 1 ☐ Yes 2	sy findings available pletion of cause of
ician; The certicate ector, pag	Be (25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Deat			I,	ssisted iving
nding Physician: th. After this cerifica funeral director, p	7: To	1 ☐ Yes 2 🗷 No 27. Manner of Death	28a. Date of Injury	28b. Tim	ne of 28c. Injur	er: 4 □ Nursing Hory at		how injury occ		
death. ctor: Affe	atio	1 ☐ Watural 5 ☐ Pendin 2 ☐ Accident investig	gation	ır) İnju		k? Yes 2□No				
tal or Atters as after de al Directo ed in by the	Certification: To	3 ☐ Suicide 6 ☐ Could l 4 ☐ Homicide determ		At home, farm pecify)	, street, factory, office		28f. Location City or To	(Street and Nu own, State)	mber or Rural I	Route Number,
To the Hospital or Attendil within 24 hours after deeth. To the Funeral Director: A completely filled in by the fu	Medical		ng Physician: To the best of my Examiner: On the basis of exam and manner stated.		or investigation, in my o	ppinion death occur		date and place		
To t To 1	2	29b. Signature and title of certifie	MCHUF)	29c. Licens	se number 351020		29d. Date sig	ped (Month, D	y, Year)
HaoH		30 Name and address of person	U 12934 441		P'BILLD SK	B Glu	Bun	ie, my	215	701
Sta Regista		31. Date filed (Month, Day, Year) NOV 2	8 2012 Reverse	A.	park					
		110.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 201^{vea} Wolfe 5:33 P ^M Charlotte Ann December Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick 47 Hamilton Avenue Frederick If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Director 1 🗆 M 2 😾 F 212-50-7788 65 July 30, 1947 Maryland 2 should be filed within 72 hours after death with the Maryland th end Mental Hyglene.
21 is marked oo other then "natural", or items 23a or 28e-if show treumatic event, the Medical Exeminer must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 47 Hamilton_Avenue <u>United States</u> 21701 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 X No Specify 3 Widowed 4 XDivorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Cook Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lewis Franklin Bell Anna Gean Carbaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pege 1 end 2 st Depertment of Health e Importent: If item 27 is eny Injury or other trei once. Charlotte Shade/ Daughter Hamilton Avenue, Frederick, Maryland 21701 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State Resthaven Memorial Gardens 12/5/12 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney & Basford Funeral Home MO1646 106 E. Church St., Frederick, Maryland 21701 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Les only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami ettending physicien and I for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month signed by the et d be detached fo 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Uterine Sarcoma 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? within 24 hours after death.

To the Funerel Director: After this certificate to completely filled in by the funeral director, page 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Hesidence} \) 6 \(\text{Other} \) Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1, Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funerel D Medical 29a. Certifier L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier MD D67742 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 46 B Thomas Johnson Drive un 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

40722

3. Time of Death 1751 hrs

10d. Inside City Limits 1 Yes 2 No

Approximate Interval

Between Onset and

Death

Year

Day

Country)

Division of Vital Records, P.O. Box 68760,

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ✔ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 🗸 Yes 2 No the Hospital or Attending Physician: Other Nursing Home 5 Residence 6 Other Certification: 1 V Natural 1 Yes 2 No within 24 hours after death. the Pending Accident Investigation completely filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 1, 2012 1 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W Baltimore Street, Baltimore, MD 21223 Rs I+IVA 2012 32. Registrar's Signature 31. Date filed (Month Lawe) State Registrar **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NOVEMBER 18 MICHAEL E. WALSH, JR. 8:05 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death CHARLOTTE HALL VETERANS HOME ST. MARY'S CHARLOTTE HALL Social Security Number 9. Birthplace (State or Foreign Country) MARYLAND If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🛛 M 2 🗆 F Days OCT. 3 Min. 212-16-1597 87 Director Usual Residence of Decedent permit. Page I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified and other. 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD ST. MARY'S LEONARDTOWN 10e. Street and Number 10g. Citizen of What Country? Funeral 20345 BEAUVUE COURT 20650 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: Completed 3 Divorced WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 OWNER ANTIQUE DEALER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MICHAEL E. WALSH, SR. CATHERINE GROCCA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20345 BEAUVUE COURT, LEONARDTOWN, MD JACK LEE FAULKNER, SON-IN-LAW 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State CHESAPEAKE CREMATION: 11/20/2012 4 Donation 5 Other (Specify) STEVENSVILLE, MD 21. Signature of Funeral Service Licensee FELLOWS AND FUNERAL 200 SOUTH HARRISON STREET, EASTON, MD MERCERO JOHN R. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause ach line Interval Between ZL Immediate Cause (Final Onset and Death 1'm ers Physician/ disease or condition resulting in death)) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a conse juence of attending physician and I for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Ectopic pregnancy Pregnant at time of death Month signed by t d be detach Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy eral Director: After this certificate I filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No Yes 2 No 8 B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State, within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 40037228 MD completed cause of death (Item 23a) (Type, Print) 20622 CAFFERTY, 29449 CHARLOTTE HALL ROAD, CHARLOTTE HALL, MD RSX+IVA STEPHEN MD

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Year Month Elmer Young 2012 Medical Mary 2:25 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Talbot Genesis HealthCare The Pines Easton If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Mir **Director** -03-1926 MIRRY land or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Easton 4 5 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 21601 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married 5 þ Mary Young Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify "natural", Completed 3 Divorced 4 Divorced Black the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Home maker Someone and Mental Hygie is marked other other traumatic event, Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ e 1 and 2 should be of Health and Menta Alfronia Hazelton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Fruitland Maruland Baltimore, 20a. Method of Disposition 206. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date permit, Page 1 Department of Important: If it any injury or o ■ Burial 2 ☐ Cremation 3 ☐ Removal from State Paradise 11-24-12 4 Donation 5 Other (Specify) Trappe 21. Sign of Funeral Service Licensee 22. Name and Address of Facility Rennie Smith Funeral Home Isabella Street Salisbury, Md. 21801 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Failure to thrive disease or condition resulting in death) days/weeks Medical Examiner Advanced Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Examiner Due to or as a consequence of been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sional disorder, hypertensive heart disa 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? , ostpartuitis , mild chronic kidney disease within 24 hours after death.

To the Funeral Director: After this certificate has be completed filled in by the funeral director, page 2 s performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Hospital Other: ျှ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Underlied Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Ucertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier mylia FNP-BL R162359 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 610 Dutchmans Ln.

Easton

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death ecedent's Name (First, Middle, Last) Date of Death Physician/ NºCC Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Seasons Hospice at Northwest Randallstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Days Hours 1 **X** M 2 □ F Director 216-28-7569 80 MD Sept 24 1932 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 ☐ Yes 2X No MD Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21133 8518 Church Lane 12. Was Decedent Ever in U.S. Armed Forces? 105 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, V Yes 2 No 1053-Tes, Give 1055 Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 No Specify: 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Academy Pool Service operator of pool service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Florence Lillian Schwartz Harry L. Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1730 Route 32, Sykesville, MD 21784 Michael Allen (son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🄀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Sykesville, MD Lake View Memorial 12-18-12 21. Signature of Funeral Şervice Licensee 22. Name and Address of Facility Haight Funeral Home & Chape1 Brun L. Haight Box 195 Sykesville, MD 21784 P.O. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Lung cancer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day i signed by the at g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of To the Hospital or Attending Physician: The law within 24 bours after death.
withe Funeral Director: After this certificate has i completely filled in by the funeral director, page 2. autopsy death? Yes 2 1 1 Yes 2 🗆 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 2 1 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifie certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Wskaj apartneno D0057465 12/14/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltomine MD 21209 NS Keyapa Ksemo N 5203 2835 Smith 31. Date filed (Month, Day, Year) 32. Registrar's Sig State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Month Year 093QM era Allen 2012 December 09 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore County NorthWest Hospita Kandallstown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 1 🗆 M 2 🔀 F Min. Hours MARYLAND B **Director** 217-20-9708 March 22. Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertial Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🕅 No <u>MARYLAN</u>D BALTIMORE CO BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2102 LUKEWOOD DR. 21207 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: BLACK 3 🕅 Widowed 4 🗆 Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HEALTH 12vrs PSYCHIATRIC NURSE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ SAMUEL MYERS PAULINE DORSEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Claudette Harvin/Daughter 4101 Fox Hollow Ln., Randallstown, Md., 21133 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ABurial 2 Cremation 3 Removal from State ARBUTUS MEMORIAL 4 ☐ Donation 5 ☐ Other (Specify) 12-14-12 BALTIMORE, MARYLAND 21. Signatur of Funeral ervice Lice WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final Ptwsician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) 2 🗌 No q 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 Yes 1 Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No 10 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural Certificate: 28d. Describe how injury occurred injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation after death Director: / Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, filled in by determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar

only one)

29b. Signature and title of certifie

NorthWest 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5401 Old Court Road, Randales town, MD

29d. Date signed (Month, Day, Year)

Percentary 7, 2012

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			State Registrar		**	Certificate	of L	Death		Reg. No.		
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	Examir		4a. Facility Name (if not institution, gir 3616 FERNAC!	ve street and number)		4b. City,		LOCation of Death		4c. Coun	ty of Death	
	Funeral Director		5. Social Security Number 6. 219-20-6937	Sex 7. Ag	e (In yrs. last birt	hday) If Under Months Yrs.	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da		9. Birthp Count	
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Baltimore,	e 1 and t of He If Item or othe		20a. Method of Disposition 1 D Burial 2 Cremation 3		20b. Place of cemeter	Disposition (Namy, crematory or ot	e of	1	Date	20c. Location		
ti Ti	permit. Page 1 Department of Important: If I any Injury or once.		4 ☐ Donation 5 ☐ Other Spec	cify)	Loudo	7/	Ce Me	1 /	15/12	Bala		d.
Ba	permit. Departr Importa any Inju		21. Signature of Fine VS rvice Ice	ller		22. Name and	_	ss of Pacility MI	one B	alto n	A. 2	shapel 1012
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12 Box 68	ne death certificate be the attending physicisiched for use as the bu	Completed by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal death	3 ☐ Ectopic p 5 ☐ Other (spe		у			ate of delive	ry Day Year
Z rds, P.0	To the Hospital or Attending Physician: The law requires that the des within 24 hours after death. To the Funerel Director: After this certificate has been signed by the scompletely filled in by the funeral director, page 2 should be detached	ed by Pi	Part II. Other significant conditions	contributing to death b	ut not resulting in	n the underlying c	ause giv	ren in Part I.	23e. Did to	/		e cause of death?
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η. 🗖	To the within 2 To the Comple		29b. Signature and title of certifier	Mal	Men			number 130/2		29d. Date signe		
V			30. Name and address of person who	completed cause of de	eath (Item 23a) (1	yge, Print)		5/ 1	Rillo.	MI	212	7/8
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#18perFH,G935,175/2013,WS
State of Maryland / Department of Health and Mental Hygiene? 0 | 2 40728 1 - State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month :48 AM Medical Facility Name (if not institution, give street and number Examiner or Location of Death 4c. County of Death Vottingham imore **Funeral** 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Min. Director 1 DM 2 W 19/1936 ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Funeral Director Himore 1 ☑ Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? Vottingham 21229 1SA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever Armed Forces? 11. Marital Status 14 Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after coppartment of Health and Mental Hygiene. Important: If item 27 is marked other than "nature." 1 Never Married 2 Married Black, White, etc. Completed by ☐ Yes 2 No 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes. Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work dene during most of working the DO NOT use retired) 15. Decedent's Education 16b Kind of Business/Industry (Specify only highest grade comp Elementary/Secondary (0-12) College (1-4 or 5+) vears Be Baltimore, Maryland 17. Pather's Name (First, Middle, Last ဂ္ of Rural Raute Number, City or Town, State, Zip Code) ham Method of Disposition 20b. Place of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Kesville, MD 21. Signature of Funeral Service/Ecense Fmore Nat'I 23a. Part 1. Ent of the disease shock, or heart ailure disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1000 Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate
Cause (Disease or injury Due to (or as a consequence of): igned by the attending physician and be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 5 Other (specify) 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an Director: After this certificate has autonsy death? 1 ☐ Yes 2 DEN 1 ☐ Yes 2 ☐ No 25. Was case referred to medical completely filled in by the funeral director, Certificate: To Be 26. Place of Death (Check only one) examiner? 2 X No Other: 4 Nursing Home 5 Residence 6 C Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number hours after City or Town, State) within 24 hours Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) and manner as stated. 29a Certifier (Check 3 Certifying Nurse P 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 9019 В 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) I MINI 31. Date filed (Month, Day, Year) 32 egistrar's Signatu State Registrar

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State of Maryland / Department of Health and Mental Hygiene 0 | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month ANDREA BROWN ΔM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SAMAKITAN 4000 ItOSPI DAZ BATTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 8. Date of Birth Days Hours (Month, Day, Year) Director 217-54-404 1 M 2 M 601 -20-1951 Usual Residence of Decedent item 27 is marked other than "nature!", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State filed within 72 hours efter death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits imore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21239 U5A 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces?

1 Yes 2 No Black White etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene, Elementary/Secondary (0-12) College (1-4 or 5+) eacher Be 17. Father's Name (First, Middle, Last) t, Pege 1 and 2 should be filed tment of Health and Mental H tant: If item 27 is marked ot 18. Mother's Name (First, Middle, Maiden Surname) မ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) le 000 MD 21239 20a. Method of Disposition 20b. Place of Disposition (Name of Cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit, Pege Depertment o Important: If any injury or once. 4 Donation 5 Other (Specify) remation 12-21-2012 tanover Mo 21. Signature of Pun and Service Licensee 22. Name and Address of Facility a uchn C. Greene Fineral Serveces ork 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or conditio resulting in death) RIGHT VENTRICULAR HEART 48 Hours Medical Due to (or as a consequence of): Examiner HUPERTENSION PULMONAMY UCANS Sequentially list conditions. if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). burlel-transi To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): signed by the ettending physician defached for use as the burlel Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ NSTEMI 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should SEPSIS. DUE TO ASPIRATION PNEUMONIA. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 V No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 힏 1 ☐ Yes 2 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at After 28d. Describe how injury occurred 1 Natural e Hosp... in 24 hours after obus... the Funeral Director: Afte 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier MD12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21239 5601 LOCH TISHER 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Thomas John Black PM^M December 7:25 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Memorial Hospital Havre de Grace Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year,
May 23, 1 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ★ M 2 □ F Country) 214-40-8589 72 **Director** Maryland Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Harford Aberdeen 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 1317 N. Stepney Road 21001 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 24 No Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates white Completed 3 K Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) security guard and Mental Hygie is marked other security agency Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Thomas Black injury or other traumatic Katherine Ann Whithers permit. Page 1 and 2 should Department of Health and Me Important: If item 27 is mar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Black/brother 4307 Camelia Road Nottingham, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licen Rona d S STate Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (v) as a consequence cf, the Hospital or Attending Physician: The law requires that the death certificate be executed page 2 should be detached for use as the burial-transi that initiated events attending physician and resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Other (specify) Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 X Unknown 2 🗌 No Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? After this certificate 1 Tyes Be 25. Was case referred to medical examiner? g 26. Place of Death (Check only one) of Vit. 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Tes Inpatient 2 ER/Outpatient 3 DOA Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Division Accident
Suicide
Homicide Investigation within 24 hours at er deat To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the be of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title rienges (Item 23a) (Type, Prin 30. Name and address of person who completed

State

Registrar

31. Date filed (Month, Day, Year)

ack

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Terry Brumley 4157 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Joseph Richey Hospice Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) Funeral 7. Age (In vrs. last birthday) Days Hours (Month, Day, Year) 432-02-8974 Director 1 🕅 M 2 🗆 F 55 Mar 16, 1957 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 🖺 Yes 2 🗆 No Brooklyn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21225 USA Funera 951 Benhill Road unk 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. à 1 Never Married 2 Married 1 ☐ Yes 2 🔯 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) body & fender repair unk automotive Be unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 951 Benhill Road Brooklyn, MD Rita Wright/friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 X Other (Specify) Signature of Euneral Service Licensee Konal S 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Diffector Baltimore, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Cause (Disease or injury Exami attending physician and I for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Terry Brumley Division of Whal Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No

9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) cate has been signed by the cage 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? performed this certificate 2 🗆 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manger of Death Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. The discrete project of the desist of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's S State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 40732 1 - For State Registrar Certificate of Death Rea No 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ DEcember 4, 201^{Year} 5:10 AMM Matthew McCoy Bailey Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Keswick Multi Care Center Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Hours Director 1 X M 2 - F 69 223-56-5782 Mar 18, 1943 Virginia Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location Director 1X Yes 2 ☐ No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21215 4124 Fairview Avenue 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No
If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify black. Specify: Completed 3 Widowed 4 Divorced 64-66 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) carpentry home improvements Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H ည Robert Bailey Sr Ruth Edith Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau once. 1213 Walker Avenue Baltimore, MD Matthew Bailey Jr/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🛛 Other (Specify) in state 21. Signature of Funeral Service Licenses Ronal II S. Wade Prector ²² State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. CEVEBVAL ACCIDENT Immediate Cause (Final VASCULAV Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical law requires that the death certificate be for use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? g Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by d 150rder 1 ☐ Yes 2, ☐ No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available 24a. Was an has prior to completion of cause of death? autopsy Yes 1 Yes Be 25. Was case referred to medica Division of Vital 26. Place of Death (Check only one) Hospital Other 2 NO. မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending within 24 hours after death. To the Funeral Director: After injury 1 Natural 5 Pending 1 Yes 2 No Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one)

Registrar DHMH 17 Rev 06-2011

State

29b. Signature and title of certifie

DEC 1

wall on in

DON M.D.

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar

Box 68760

P.O.

35102

5901 North CHarles Street Baltimore Mary land

Box 68760. P.O. Records, Division of Vital

certificate or Attending Physician: this certific al director, After thi funeral of the Hospital

Notice...
within 24 hours after co....
To the Funeral Director: Aft

Certification: To

Medical

State Registrar

5 Pending

XERNP

investigation

6 Could not be determined

1 ☐ Yes 2 No

27. Man of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

one)

4 Homicide

(Check only

29b. Signature and title of certifier

29c. License number

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

BAHIMORE, MD ZIZOI

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. EUTAW St.

28a. Date of Injury (Month, Day, Year)

10A 31. Date filed (Month, Day, Year)

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

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**State amend #31 Per DVR G934 12/17/2012

State of Maryland / Department of Health and Mental Hygiene 2 0 2

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Type Indelible Ink. Ensure All Copies Are 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 28, 2012 12:30 PMM Louis Benzi Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Hyattsville Prince George's 3005 Nicholson Street 9. Birthplace (State or Foreign unk 5. Social Security Number 578-50-2695 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **Funeral** Hours (Month, Day, Year) **Director** 1 **X** M 2 □ F Yrs 91 Apr 27, 1921 28a-f show 10a. State 10d. Inside City Limits Director 10b. County 10c. City, Town or Location must be notified at 1 ☐ Yes 2 😾 No Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or Funeral 3005 Nicholson Street 20782 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "man any injury or other transmissions." Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married unk If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: white Completed 3 ★ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Carpenter Building unk unk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, unk unk ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4327 Gallatin Street Hyattsville, Md. 20781 unk 19a. Informant's Name/Relationship (Type, Print) Raul JBathGaryeyine Bersenal rep 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ▼ Other (Specify) in rvice Licensee 21. Signature of Funeral Service Lice Ronald S 22. Name and Address of Facility
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Baltimore, MD 21201 Next 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or a consequence of): weeks disease or condition Medical resulting in death) Examiner 10121C Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
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1 Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Completed 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 N 2 No 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier

P.O. Box 68760 Division of Vital Records, within 24 hours after

To the Funeral Direct

completely filled in by

> State Registrar

31. Date filed (M th, Day, Year)

(Check

29b. Signature and title

1140 MD

5280

acumed at the time date and place

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nume Practitioner To the best of my knowledge.

MEVER Varnum

32, Registrar's Signature

STNE Washington DC.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Margaret Louise Clark 9:08 Ам 2012 Medical December 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center For Hospice Baltimore Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Funeral Director 220 24 8015 100 1 □ M 2 13 F Yrs. July 28, 1912 Pennsylvania end 2 should be filed within 72 hours efter death with the Merylend Heelth and Mentel Hyglene. tem 27 is merked other then "neturel", or items 23e or 28e-f show ther treumestic event, the Medical Examinar must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore 1 Tes 2 No Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 233 Nanticoke Rd. 21221 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. <u>۾</u> 1 Never Married 2 Mamied 1 ☐ Yes 2 ☑ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Housewife Own Home B 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Walter Jones Verna Spangler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) theeith Item 27 other tre Constance L. Markley (Daughter) 233 Nanticoke Rd. Baltimore, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of important: If it
eny injury or o Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 12/17/2012 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. M 1407 Old Fastern Avenue Essex, Maryland 21221 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ cast Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) signed by the ettending physicien and d be deteched for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FFMALE yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Month 5 Other (specify) 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? δ Records, cete hes been sig r, pege 2 should b Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Division of Vital funerel director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 173 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred el or Attending F s efter death. I Director: After i After 1 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No the Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by To the Hospitel o within 24 hours of To the Funerel DI completely filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARLES AARON W 6701 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death W. Kennedy Cromwell, III Physician/ 73 2012 December 12:15p м Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Sykesville Fairhaven If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 219-18-5309 1 X M 2 □ F **Director** Yrs May 31 1924 MD or 28a-f show notified at show 10c. City, Town or Location 10d. Inside City Limits Director MD Carrol1 Sykesville 1 ☐ Yes 2 X No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ms 23a or must be r or Funeral 21784 USA 7200 Third Avenue I Hygiene. other than "natural", or items / vent, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Ves 2 No WWII
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married within 72 hours after Saltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: Specify: white 3 XWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) U.S. Government Elementary/Secondary (0-12) College (1-4 or 5+) foreign service officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H
27 is marked of
traumatic ever Margaret Oliver Dunn မ W. Kennedy Cromwell Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a 905 S. Bond St., Baltimore, MD 21231 Mr. Pierce Dunn (executor) other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State <u>=</u> . 1 Burial 2 X Cremation 3 Removal from State Department o Important: If any injury or once. All County Cremation 12-15-12 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Parge Stanget Sturbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ 1 yo cardial disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): and that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician a should be detached for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 1 Yes 2 No 1 🗌 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No s after death.

I Director: After the Certificate: 28b. Time of 28d. Describe how injury occurred 1X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral C completely filled 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) D 34849 December 13 2012

DHMH 17 Rev 06-2011

Registrar

0 V

& Idershing MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Jan MD 1645 Libertz Rd

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #23a&e Per PHY C934 12/17/2012 JH
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ Alice Louise Corbett December 10. 2012 5:15 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Renaissance Gardens @ Charlestown Catonsville Baltimore If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month Day, 1<u>931</u> 1 🗌 M 2 🛚 Rhode Island Jan Director 010-24-0334 81 Usual Residence of Decedent ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10a State 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Tes 2 X No Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 709 Maiden Choice Lane 21228 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 X Widowed 4 Divorced Specify: Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) US Government Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with.
Department of Health and Mental Hygiene Important: If item 27 is marked other tha any injury or other traumatic..... 12 n/a Printing Specialist Census Bureau Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Elliot Raymond Milliken Nellie Ε. McMann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Louise Baker/Daughter 728 Chapel Ridge Road, Lutherville, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 12/12/2012 Glen Burnie, Maryland Bryan W. Clary 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, Maryland 21093 23a. Part 1. Enjerthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to for as a consequence on and I-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): the attending physician a hed for use as the burial-Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery Month Dav Year signed by the a d be detached f 1 Yes 2 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2: performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 🗆 Yes 2 / No Other: ျှ 1 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpa Nursing Home 5 Residence 6 Other (Specify, funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) I Director: After to in by the funeral 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hours after Hospital within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier CRNT

Registrar

DHMH 17 Rev 7/2009

State

Kathy Davis

racke

Lane Catonsville MD 21228

ess of person who completed cause of death (Item 23a) (Type, Print)

709 Warden Choice

32. Registrar's Synature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dec. Physician/ 13^{Day} 2012 Joanne Helen Clopein 12:15 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard Gilchrist Hospice Care Columbia 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Days Hours Director 219 32 7305 1 M 2 XF Yrs. 04/13/1937 item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 Yes 2 No MD Howard Ellicott City 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21042 10226 Dolliter Court United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 72 hours after 1 ☐ Yes 2X No Specify: Specify: White 3 XWidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medicone. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Harry Phipps Helen unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4064 Heritage Hill Lane Ellicott City, MD 21042 Sue Mascaro/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 KBurial 2 Cremation 3 Removal from State Crest Lawn Mem. Gard. 12-21-2012 Marriottsville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final STAGE ENA! Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Completed by Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 🗆 No 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 × No Other: HOSPICE 1 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 💆 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 📈 Natural 5 Pending ☐ Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifie 1 Z Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title 29c. License number D72139 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COLUMBIA MD 21044 ABBAS MD 6336 CEDAR LANE Q. 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

Baltimore, Maryland 21215-0036

Box 68760

Division of Vital Records, P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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920	ified within 72 hours after death with the Maryland ital Hygiene. so other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ρ	1 [arital Status ☐ Never Marrie 【 Widowed 4		12. Was Deced Armed Force 1 Yes 3 If Yes, Give Year or Date	ces? 2 No			nt of Hispanic ∕ Cuban, Mex KNo Spe		ecify Yes or No- Rican, etc.)		14. Race - Ame Black, White Specify: Whi	e, etc.
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Baltimore,			1		Cremation	3 Removal from S	State (cemetery, crem	atory or other	er place)		Date		cation - City or	
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Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trans.	Physician/M	in 1	las decedent p the past 12 m Yes 2	onths?		irth 2 🗍 Fetant at time of	al death 3 🗌	Ectopic pre				2	23d. Date of del Month	ivery Day Year
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Division of Vital Records,	sician: The law r certificate has b lirector, page 2 s	Completed										24a. Was auto perfo 1 \(\sum \) Yes		prior to death?	topsy findings available completion of cause of
/ital	sician certif directo	To Be	exa	is case referred aminer? Yes 2		Hospital:	0.0	LED/Out-us-		Othori	Death (Check				
n of ∖	rding Phys th. After this funeral di		27. Ma	nner of Death Natural Accident	5 Pending	28a. Date of (Month,		ER/Outpatient 28b. Time of injury		Injury at work?		me 5 □ Resi 28d. Describe I		Other (Speciococurred	ify)
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_	ne Hospitu n 24 hours ne Funera pletely fille	Medical	(0	Check 2	Medical Ex	Physician: To the best caminer: On the basis Nurse Practitioner: 1	of examinatio	n and/or investi	gation, in my	opinion, deat	th occurred at	the time, date a	and place,	and due to the o	ause(s) and manner stated
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Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Clarence Edward Cramblitt Jr Medical December 12:42 PM 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Joseph Richey Hospice Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Hours (Month, Day, Year) Director 219-54-4923 1 X M 2 □ F Yrs 61 Apr 5, 1951 Usual Residence of Decede Maryland 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Prince George's Laure1 1 ☐ Yes 2X☐ No the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9427 Nicklauf Lane 20708 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 11. Mantal Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married i and 2 should be filed within 72 hours after of Health and Mental Hygiene.
Item 27 is marked other than "natural", or Black, White, etc. δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 Divorced 4 Divorced Completed Specify: white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 11 0 bartender tavern Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Clarence E. Cramblitt Sr Mary Starr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah Bopst/sister 1525 Driver Road Marriottsville, MD 21104 20a. Method of Disposition 20b. Place of Disposition (Name of Page 1 Department of I Important: If its any injury or of once. Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☑ Other (Specify) in state Signatur of Europe I Servi State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to as a consequence Brain metastasis disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending p IE EEMALE use. 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Pregnant at time of death Month ed by the a Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? Records, hydronephrosis right 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ■ No 24a. Was an autopsy
performed?

1 Yes 2 No effussion the funeral director, 25 Was case referred to medical Vital æ 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) OSP (Ce မှ this 1 Inpatient 2 ER/Outpatient 3 DOA ð 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred or Attending Natural 5 Pending Division 2 Accident 1 Yes 2 No Investigation within 24 hours after deat To the Funeral Director: completely filled in by the 6 ☐ Could not be filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 In Medical Examiner: On the pasts of examination and/of investigation, in this opinion, detail occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar

12-42pm

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Balt, MD. 21236

Brent

cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State	State	of Mary	/land /					and N	lental Hy	/gien	e 2 O	12	1. 0	71.1
		Registrar	(4)			Cer	tificat	e of L	eath			Reg. N	VOL U	12	40	141
Physicia		1. Decedent's Name (First, Middle, Franklin Cart	•								2. Date of De Month DEcemb		Day 8 20	Year 112		of Death PM M
Medic Examin		4a. Facility Name (if not institution,		nber)			4b. City,	Town, or	Location	of Death	DECCINE	- 1	c. County		1791	111
		Gilchrist Ho	spice					Tows	son				Ва	altim	ore	
Funeral			S. Sex	7. Age (In		oirthday)	If Unde Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bit (Month, Da)	9. Birthp Coun	place (State	e or Foreign
Director		215-56-1824 Usual Residence of Decedent	1 🕅 M 2 🗆 F	6	62	Yrs.					Sept 2				yland	
show	9	10a. State 10b. County		100	c. City, To	wn or Loc	ation							1	0d. Inside	City Limits
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h with	Funeral Director	812 Benninghaus	Road						2121	. 2			U	SA		
daat		11. Marital Status	12. Was Dece Armed Fo	edent Ever i proes?, 2 4-No	in U.S.	13. V	Vas Deced Yes, spec	lent of Hi cify Cuba	spanic Ori n, Mexicar	gin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)	-		e - Americ k, White,		
aftar	d by	1 ☐ Never Married 2 🖾 Marrie 3 ☐ Widowed 4 ☐ Divorced	1 ∐ Yes If Yes, Giv Year or D	ve		1	☐ Yes	2 🌠 No	Specify:					bla		
hours	Completed	15. Decedent	's Education		16	6a. Deced				_		16b.	Kind of B	usiness/lne	dustry	
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yglan yglan her ti	De C	12	2			me	chan:					se	lf em	np1oy	ed	-
	일	17. Father's Name (First, Middle, La	st)				1	ınk	18. Moth	er's Nam	e (First, Middle	, Maide	n Sumame	9)		unk
ould F Berl		19a. Informant's Name/Relationshi	o (Type, Print)		11	Qh Mailin	n Address	(Street a	and Numbe	er or Rura	al Route Numbe	er City	or Town S	State Zin (Code)	
12 sh aith a 27 le		Mattie Carter/s					•	•			Baltim		,	212		
of Han		20a. Method of Disposition				of Dispos	sition (Nar	ne of			Date		Location -	City or To	wn, State	
Page ment o tent: If ury or		1 ☐ Burial 2 ☐ Cremation : 4 ☐ Donation 5 🔯 Other (Sp			Como	acry, crom	idiory or o	ares plao								
permit. Page 1 of Pepartment of Pepartment of Pepartment: If Its any Injury or of any Injury or of ones.		21. Signature of Funeral Service Lin Ronald S	wade	Direc	tor						l 655 W	. В <i>є</i>	altim	ore S	tree	t
		23a. Part 1. Enter the disease, or o	omplications that	caused the	death. Do				MD 2			rrest.			Approxin	nate
Physician/		shack, or heart failure. List on Immediate Cause (Final		-		1-			,						Interval E Onset an	Between
Medical		disease or condition resulting in death) a. Due to (or as a consequence of):												Mil	1 Coll	
Examiner	_	Sequentially list conditions,														
a t	틸	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying														
be executed sician and burial-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	(or as a cor	nsequence	e off:								_		
be e siciar buri	dical		d													
ificate of phy as the	Med	IF FEMALE:	- u													
h card tandir or usa	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, out 1 ☐ Live	tcome of pr Birth 2		ath 3□	Ectopic	pregnanc	у					te of delive	•	
the at	Physician/Me	1 Yes 2 No 9 Unknown	4 ∐ Preg 9 ☐ Unki	nant at time nown	e of death	n 5□	Other (sp	ecify)					Мо	nth	Day	Year
ad by datac	된	Part II. Other significant condition	s contributing to d	leath but no	ot resultin	g in the ur	nderlying	cause giv	en in Part	1.	23e. Did 1	tobacco	use contr	ribute to th	ne cause o	f death?
sign sign	d b										1 🗆	Yes	2 🗆 No	3 🗆 Prot	pably 4 E	Unknown
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lan: T	Be	25. Was case referred to medical examiner?						26. Pla	ce of Dea	th (C he ci		2 (3	NO	i Li ies	2 🗆 140	
hysica his ca il dire	2	1 ☐ Yes 2 ☑ No	Hospital:	Inpatient	2 🗆 ER/	Outpatien	t 3 □ D	Othe	er: 4 □ No	ursing Ho	me 5 Resi	idence	6 ⊡-Othe	er (Specify	Hex	es io
Ilng P	Certificate:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date (Mon	of injury th, Day, Yea		o. Time of injury		8c. Injury work	?		28d. Describe	how inju	ury occurre	ed		1
daath daath stor: /	# #	2 ☐ Accident Investiga 3 ☐ Suicide 6 ☐ Could n	at he	of Injury -	At home	form stre	M est factor		Yes 2 .	No		· ·		/		
al or A after Direct	ဦ	4 ☐ Hornicide determin		ing, etc. (Sp		iann, stre	et, ractor	<i>,</i> , опісе		1	28f. Location (City or To			er or Rural	Route Nui	mber,
oapite hours unerel	edical	29a. Certifier 1 Certifying	Physician: To the b	pest of my k	knowledge	e, death o	ccurred a	t the time	, date and	place, a	nd due to the c	ause(s)	and mann	ner as state	ed.	
To the Hospital or Attending Physician: The isw raquires that the death certificate within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicompiately filled in by the funeral director, page 2 should be deteched for use as the	Me	only one) 3 L/I Certifying !	aminer: On the bar furse Practitioner	sis of examil r: To the bes	st of my kr	vor investi nowledge,	death occ	urred at ti	ne time, da	te and pla	tine time, date ace, and due to	and place the cau	ce, and due se(s) and n	e to the cau	use(s) and rated.	manner state
5 4 5 6 8		29b. Signature and title of certifier					290	. License	number			29d. D	ate signed	0		
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		30. Name and address of person w	ho completed caus	se of death		a) (Type, P	rint)	0	+ 6	- 1	0 2,10	_	R-D	£1	W	10
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Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

12-08984 Stephen Lee Delph Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

amend # State of Mary and Department of Health and Mental Hygiene

2012 40742

			1- For State C6	ertificate of i	Death		Re	eg. No.	12 40115
	Physicia al Exami		Decedent's Name (First, Middle,Last)				2. Date of Deal Month November		3. Time of Death 2138 hrs
leuica	II EXAIIII	ner	Stephen Lee Delph 4a. Facility Name (if not institution, give street and number)	41	p. City. Town. or	r Location of Dea		4c. County of D	
			1370 North Main Street		Hampstead			Carroll	
	Funeral		CITI	. last birthday)	If Under 1 Yea			l c	9. 8irthplace (State or oreign
	Director		215-60-2707 _{1 M 2 F} 5	59 Yrs.	Months Day	s Hours M	In Apr 18	3, 1953	Country) Kentucky
	any		Usual Residence of Decedent 10a State 10b County 10c. Cit	ty, Town or Locatio	in				10d. Inside City Limits
	≱ .1		MD Carroll	Hampstea					1 Yes 2 X No
	Aaryland 28a-f show i at once.	Director	10e. Street and Number		10f. Zip Code		1	0g. Citizen of What	
	2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at ones.	Dire	1370 N. Main Street		210	74		USA	
	th with	nera	11. Marital Status 1 Never Married 2 Married Armed Forces?			spanic Origin? (n, Mexican, Puer	Specify Yes or No to Rican, etc.)	- 14. Race - A White, e	American Indian, 8lack, etc.
	, or in	F	1 Yes 2 No 3 X Widowed 4 Divorced If Yes, Give Year	1 1 7	Yes 2 X No	specify:		Specify: V	white
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003	led within 72 Hygiene. other than the Medical	Completed	12 0	arl	borist			fores	
MD 21215-0036	uld be filed within Mental Hygiene. marked other the c event, the Medi	Be C	17. Father's Name (First, Middle, Last) Lester Delph, Jr		unk		ne (First, Middle, P phine Da		unk
212	ould be fi Mental I marked ic event,		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing.	Address (Stre		The same of the same	nber, City or Town,	State, Zip Code)
Ð	12 sho th and 127 is		Jacob Albright/stepson				Hanover,	PA 17331	l
	ages I and 2 shount of Health and N t: If item 27 is n other traumatic		20a. Method of Disposition 20b 1 Burial 2 Cremation 3 Removal from State	 Place of Dispositi crematory or other 		emetery,	Date	20c. Location - Ci	ity or Town, State
Baltimore,	Pages 1 ment of I- tant: If i or other		4 Donation 5 X Other Specify: in state						
Balt	permit. Page Department of Important: injury or oth		21. Signature of Funeral Schice Licenson, Directo			-			re Street
	ysician	-1	23a. Part I. Enter the disease, or complications that caused the dear	th. Do not enter the	timore, e mode of dying	MD 212 , such as cardiao	or respiratory arr	est, shock, or heart	Approximate Interval
- 1	Medical		failure List only one cause on each line. Immediate Cause (Final disease aAtheroscleroti						Between Onset and Death
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		اء	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence	os():					
		nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Of):					
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760,	cate be ex physiciar he burial	Medical	IF FEMALE: 23c. If yes, outcome of pre	egnancy				23d. Date of de	elivery
	ding p	ician/	23b. Was decedent pregnant in the past 12 months?	death	al death 3	Ectopic preg	nancy	Month	Day Year
Box 68	e death certifi the attending ed for use as 1	Physic	1 Yes 2 No 9 Unknown 4 Pregnant at time or 0	death 5 Othe	er (Specify)				
0	that the d red by the detached		Part II. Other significant conditions contributing to death but not	t resulting in the un	nderlying cause	given in Part I.	23e. Did to	bacco use contribu	ite to the cause of death?
Division of Vital Records, P.O.	ires that signed be deta	d by					1 ✓ Yes	s 2 No 3	Probably 4 Unknown
g	w requir is been s should	Completed			_		24a. Was autop		ere autopsy findings available or to completion of cause of
Şec	The law cate has page 2 sl	E					perfo 1 ✓ Yes		ath? ✓ Yes 2 No
<u> </u>	certificate ector, page	Be	25. Was case referred to medical examiner?		26.Plac	e of Death (Chec	k only one)		
Ž	ding Physician: The l. After this certificate funeral director, page	ᅙ	examiner? 1 Yes 2 No 27. Manner of Death No Hospital: 1 Inpatient 2 28a. Date of Injury	ER/Outpatient		Other Nurs		Residence 6 🗹	
0 10	nding Pl th. r: After e funera	Ö	1 Natural 5 Pending (Month, Day, Year)	200. Tittle Of [ft]	`	Yes 2 No	Zod. Describe	now injury occurred	
isi	r Atte ter dea irecto n by th	필	2 Accident Investigation 28e, Place of Injury - At	home, farm, street	, factory, office	building, etc.	28f. Location (Street and Number	or Rural Route Number, City
á	spital or Atten cours after death seral Director: filled in by the	Certification	Suicide 6 Could not be determined (Specify)				or Town, S	State)	
	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowled one) 2 Medical Examiner: On the basis of examination						
	To the To the Comp	Medical	and manner stated. 29b. Signature and title of certifier		29c. Licen				(Month, Day, Year)
			MAL BOWN		0.0	.M.E.		November 26	
	- 1		30. Name and address of person who completed cause of death (Ite	em 23a)			-		
]		Melissa Brassell, MD Assistant Medical Exam			Street, Baltim	ore, MD 2122	23	
	S	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signa	pure park					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND #8 PER FH G934 12/20/2012 JH
State of Maryland / Department of Health and Mental Hygiene 0 1 2 40743 Certificate of Death Reg. No. ent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month IRIE 6.40 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NA BALTIMORE AGNES HO SPOTAL Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Funeral 8. Date of Birth 9. Birthplace (State or Foreign SET T0-2 1-11938 Director 1 M 2 X F of Health and Mental Hygiene. Item 27 is marked other then "neture!", or items 23e or 28e-f show other treumetic event, the Mydical Examinar must be notified at 10b. County 10a Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 Yes 2 □ No DAHMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes Give 1 Yes 2 No Specify 3 Widowed 4 ☐ Divorced Year or Dates YEAR AMERICAN 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life; DO NOT use retired) College (1-4 or 5+) tERIA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname မ -dubreds hompson Informant's Name/Relationship (Type, Print) 19b. Mailing Address Street and Nymber or Rural Route Number, City or Town, State, Zip Code) MaE Edmondson ACE-Md 21229 IliAms DAHIMOSE 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of P Importent: If Its eny Injury or of cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State (AnsdownE 4 ☐ Donation 5 ☐ Other (Specify) 21. Some of Funeral Service Licen 23. Name and Address of Facility

VANGY M. WALLAGE

3405 (13. FFANKIN Baltimires MARYLANd Strant-23a. Part 1 - Interryle disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final disease or condition OVARIAN Physician/ CANCER Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): ettending physicien end for use es the buriel-trensit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical or Attending Physicien: The law requires that the death certificate be /G/G/5 > SH/RLE 4 Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year tor: After this certificate has been signed by the e the funeral director, page 2 should be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 🖾 No 3 🗆 Probably 4 🗆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ours after death.

eral Director: After this certificate has t filled in by the funeral director, page 2 s autopsy performed? Yes 2 No 2 No 1 🗌 Yes $U_{
m color}$ Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No ဂ္ 1 Tyes Other: 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide М Investigation 6 Could not be To the Hospitai or Att within 24 hours after do To the Funeral Direct completely filled in by it Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) Doe62634 Dec 12, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CELUMBIA MO 21644 AWAN TEEN 10 796 HICKING Ridge Rd 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEMBER Peter Demestihas Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MEDICAL BALTIMORE OWSON If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours 214-40-9843 Director 1**X**□ M 2 □ F 83 Nov. 16 1929 Greece Usual Residence of Decedent artment of Health and Mental Hygiene. ortent: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, <u>the Medical Examiner must be notified at</u> 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Baltimore Cockeysville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10535 York Road 21030 U.S.A. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Was Decedent L.S. Armed Forces? 1 Yes 2 No 14 Race - American Indian Black, White, etc. 2 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: 3 X Widowed 4 Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Restauranteur Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Stelios Demestihas Antonia Kalamas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 end 2 s if Health a item 27 i Samuel Demestihas/ Son 11 Haddington Road Lutherville. MD. 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation /5 ☐ Other (Specify) 12-15-12 Greek Orthodox Cem. Woodlawn, MD. 21. Signature of Funeral Service Licen ^{22. Name and Address of Facility} Funeral Home, Ruck Towson Funeral Home, 1050 York Rd. Towson, MD. 23a. Part 1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Exami attending physician and I for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy sate has been signed by the atter page 2 should be detached for in the past 12 months? 5 ☐ Other (specify) Pregnant at time of death Yes 2 No g Unknown a 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy within 24 hours after death.

To the Funeral Director: After this certificate to completely filled in by the funeral director, pag 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be examiner?

1 Yes 2 XNo 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 은 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 Accident Investigation 2 🗆 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Cartifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title 12.14.2012 Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar DHMH 17 Rev 06-2011

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** AM 9:47 Marcella Davan 9 December 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) December 22, 1934 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Months Days 216-30-6090 Maryland Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d Inside City Limits 1 ☐ Yes 2X No notified Director Maryland BAltimore Dundalk 28a-f 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ō must be 23a USA 21222 Funeral 7902 Kavanagh Road Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2X No Specify Specify: White þ 3 X Widowed 4 ☐ Divorced 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical than Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. 12 years Bookkeeper Financial Corp. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mario Ferro Josephine Goles ပ traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Linda Scannell Daughter 7902 Kavanagh Road, Dundalk, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of h Important: If ite any injury or ot once. 1 XBurial 2 Cremation 3 Removal from State Arlington National 5 Other (Specify) 4 Donation 21, 2012 Ft. Myer, Virginia Signature of Fut ²²Clame and Address of Facility Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Kespiratory **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Metastatic Sequentially list conditions, if any leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a concequence on): death certificate be executed burial-trai Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical the as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Tectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð of Vital Records, ate has been signe page 2 should be 1 🗌 Yes Completed 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed 1 ☐ Yes 2 ☐ No 2 00 Physician: 25. Was case referred to medical examiner? completely filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 ☐ Yes 2 ☑ No 1 Inpatient 2 🗆 ER/Outpatient 3 🗌 DQA 6 Other (Specify) 2 5 Residence this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred al or Attending P s after death. Il Director; After th Certification: Division 1 Natural 5 Pending investigation Injury 1 Tyes 2 □ No 2 Accident 3 Suicide Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) KES 100 December 9, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bach, 4940 Eastern Avenue, Baltimore, MD, 21224 Christopher 31. Date filed (Month, Day, Year) State 7 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene	20	1	2	40	17	1.
State of Maryland / Department of Health and Mental Hygiene	21	JI	4	40	, ,	7

		1- For State Registrar			Cei	rtificate	e of l	Death					Reg. No.			
Physicia	an/		dle,Last)								2.	Date of De	eath	.,		3. Time of Death
Exami	iner	Rd IIId	Ka'Mia Asha Dowe Month Day Year December 5, 2012										Г	2113 hrs		
		4a. Facility Name (if not institution	-		er)			City, To	n, or Lo	cation of	Death			County o	f Death	
		Upper Chesapeake N			-			Bel Air						Harford		
uneral		5. Social Security Number	6. Sex	7	Age (In yrs. I	ast birthda	ay)	If Under Months	Year Days	If Under Hours	24Hrs. Min.	8. Date of E	Birth(MM	/DD/YYYY	9. Birth Foreian	place (State or MARYLAND
rector		518-97-9596	1 M	2 XX F		0	Yrs.	7	Days	Hours	IVIII.	06/29	9/20	12	Cou	
		Usual Residence of Decedent		•												
w any		10a. State 10b. County			10c. City	, Town or	Locatio	n								10d. Inside City Limits
28a-f show d at once,	5	MARYLAND HA	RFORI	D CO				EDG	EWO(OD						1 Yes 2 X No
28a-	Director	10e. Street and Number						10f. Zip C	ode				10g. Cit	izen of Wh	at Count	ry?
3a or otifie	<u> </u>		BRANG	CH WAY				2	1040)			U	S.A.		
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hao	Completed	Diementary/Secondary (0-12)	'	College (1-4 (or 5+)			N/A						N	/A	
giene ther t	E	17. Father's Name (First, Middle	e Last)			<u> </u>		N/A	18	Mother's	Name (F	irst, Middle	Maiden			
a Hy	Bec			30								. Dow		, Garrianio,		
Ment mari	0.					19b. N	Mailing A	Address	Street a			al Route N		ity or Towr	n, State,	Zip Code)
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Department of Health and Mental Hygiene. Important: If item 27 is marked other thao "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition				Place of D	ispositi	ion (Name				Date				own, State
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ortan		4 Denation 5 Other S 21. Signature of Funeral Service)	M.	ETRO					12-1					MARYLAND
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		23b. Was decedent pregnant in t past 12 months?		1 Live birth		2	Feta	il death	3	Ectopic	pregnanc	у		Month	•	ay Year
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	۱	27. Manner of Death		28a. Date of I (Month, Da	njury y,Year)	28b. Tim	e of Inju			at Work?		3d. Describ	e how inj	ury occurre	∍d	
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		3 Suicide 6 Coudete 4 Homicide 29a. Certifier 1 Certifying Fore) 2 Medical Exception 29b. Signature and title of certifier 30. Name and address of person Ling Li, MD Assista	Physician: aminer:On ani er who com ant Med	To the best of an the basis of end manner state	xamination and.	n 23a) W. Balt	imore	29c. t	icense r	eath occunumber	urred at ti	he time, dat	e and place	ace, and du	ue to the	th, Day, Year)

State of Maryland PEBenarment of Health and Mental Hygiene For State Registrar Reg. No. 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Da Shirley Jean Evans ZOIZ 360 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospital Center Westminster Carrol1 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 🗆 M 2 🔀 F Hours 181-26-4157 0170271935 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. The anti-filed 23 or 28a-f show ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or or other traumatic event, the Medical Examiner must be notified at ury or or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 Yes 2 No Md. Carrol1 **Eldersburg** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1221 Sapphire Ct. 21784 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Force Black, White, etc 1 Never Married 2 Married 2 No Yes Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give 3 ☒ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Emma Christman John Walschott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clifford D. Evans (Son) 1209 Millstone Ct. Eldersburg, Md. 21784. Department of Health Important: If item 27 any injury or other the once. 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/17/2012 | Marriottesville, Md Crest Lawn 22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md. 21784. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Bilateral disease or condition week Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. physician and s the burial-trans Due to (or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown After this certificate has been signed by the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed death? 1 ☐ Yes 2 ☑ No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examinar? Hospital Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: ☐ Natural 5 Pending work? 1 ☐ Yes 2 X No To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af SUBJECT FELL 12-10-2012 4:30 PM Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1221 SAPPHIRE CT. determined HOME ELDERSBURG, MD. Medical 29a. Certifie 🕒 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signatur and title of certifie 29d. Date signed (Month, Day, Year) selo 52035 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mo 21157 CHACKO 295 Stoner Westminster 31. Date filed (Month, 32. Registrar's Sig State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Of IV State Registrar	laryland / Depa <i>Cer</i>	artment of Health a tificate of Death	and Me	entai Hygie	201	2 40748
Dhysisis	-1	Decedent's Name (First, Middle, Last)				. Date of Death		3. Time of Death
Physicia Medic	al	BERTHA OLA EVAN	S	1		December		
Examin	er	4a. Facility Name (if not institution, give street and number) CALVERT MEMORIAL HOSPITA	т.	4b. City, Town, or Location of PRINCE FRED			4c. County of D	GEORGES
Funeral	1	5. Social Security Number 6. Sex 7. Ac	ge (In yrs. last birthday)	If Under 1 Year If Under Months Days Hours		Date of Birth	9.	Birthplace (State or Foreign Country)
Director		243-40-0371 1 ☐ M 2 🗓 F Usual Residence of Decedent	89 Yrs.		1 1	CT. 28		OUTH CAROLINA
rland f show	tor	10a. State 10b. County	10c. City, Town or Loc	cation				10d. Inside City Limits
e Mary r 28a- notifie	Director	MARYLAND PRINCE GEORGES 10e. Street and Number		LUSBY				1 Tes 2 No
with th		11555 BIG SANDY RUN RD.		10f. Zip Code 20657		109	g. Citizen of What U.S.A.	Country?
death items	Funeral	11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S. 13. V	Was Decedent of Hispanic Original Street Country (1997)	gin? (Specify	y Yes or No-	14. Race - A	merican Indian,
Ind 21215-UU36 filed within 72 hours after death with the Maryland tal Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ₹ 3 🕅 Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	No	1 \square Yes 2 X No Specify:		an, 6.6.)	Black, W SpecifyAf1	rican-American
21215-0036 within 72 hours after giene. er than "natural", o , the Medical Exam	Completed	15. Decedent's Education (Specify only highest grade completed)		dent's Usual Occupation kind of work done during most	t of working	16	Sb. Kind of Busine	ess/Industry
121; thin 72 me. than '	Juo	Elementary/Secondary (0-12) College (1-4 or	5+) life. D	O NOT use retired)	t or working		OT OTHER	
nd 2 filed wi al Hygie d other	Be	6th grade 17. Father's Name (First, Middle, Last)	<u> </u>	LER 18. Mothe	er's Name (F	First, Middle, Ma	CLOTH C iden Surname)	LEANING
ylan Id be f Menta arked atic ev	욘	ABRAHAM LAND		S	USIE	FOWLER		
Maryland 2 should be filed tht and Mental Hy 27 is marked oth traumatic event		19a. Informant's Name/Relationship (Type, Print)	1	ng Address (Street and Number				
and Jean		Doris McElveen/Daughter 20a. Method of Disposition	20b. Place of Dispo	55 Big Sandy R	tun Rd Dat		y Md., 2 Oc. Location - City	
Page nent o ant: If ary or		XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	·	natory or other place) IORIAL PARK	12-15	-12 BA	ALTIMORE	, MARYLAND
Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or other		21 Supplier of Funefal Service LiGens	wÎ	Name and Address of Facilit LLIAM C BROWN 206 W NORTH A	COMM			
		27a. Vart 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lin	d the death. Do not ente			espiratory arrest	,	Approximate Interval Between
- Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	CORONA a consequence of):	ARY ART	Efy	DISE	ASS	Onset and Death
Examiner		Due to (or as	a consequence of):	TIVE ME	A 0 T	Carry	0.6	
_ #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a control donies on.			PAILO	,	
φ ω	<u>.</u> ≡ 1	Cause (Disease or injury						
ecute and Il-trans	Exami	that initiated events	a consequence of):	TENSION				
U be executed sician and e burial-transi	ical Examiner	that initiated events	a consequence of):		THMIR	5 -		
ate do	edical	that initiated events resulting in death) Last C. Due to (or as d	a consequence of): CARDI	TENSION AC ARRY	TMMIA	<u>.</u>	1	
5X 68/60 ath certificate be executed attending physician and for use as the burial-trans	edical	that initiated events resulting in death) Last C. Due to (or as d	a consequence of): CARD e of pregnancy 2 Fetal death 3	Ac ARRY	TMMIA	S -	23d. Date of Month	delivery Day Year
). Box 68/60 the death certificate be execute by the attending physician and ached for use as the burial-trans	edical	that initiated events resulting in death) Last C. Due to (or as d	a consequence of): CARD e of pregnancy 2 Fetal death 3	AC ARRY	THMIA	J -	1	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 40750 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 3:00 AMM Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death Examiner 4c. County of Death Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Number 6. Sex **Funeral** Days Hours Min **Director** 213-30-3860 Usual Residence of Deced 1 □ M 2 💢 F Dec 4, 1931 81 28a-f shov 10a. State 10c. City, Town or Location nan "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10b. County 10d. Inside City Limits Director 1 Yes 2 X No MD Harford Bel Air 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 956 Tide Road #D 21014 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. unk þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify. black 3 Widowed 4 Divorced Completed unk 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry A and Mental Hygiene.

77 is marked other than "r (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) unk unk Be unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) 2 Department of Health and Important: If item 27 is n any injury or other traum once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Upper Chesapeake Med Ctr 500 Upper Chesapeake Drive Bel Air, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) in State 21. Signature of Funeral Service License Ronald S. Warde, Director 22. Name and Address of Facility
State Anatomy Board
Baltimore, MD 21201 655 W. Baltimore Street 23a. Part | Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury physician and s the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 \(\subseteq \) Yes 2 \(\overline{\mathbb{N}} \) No signed by the a 1 Yes 2 2 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🗙 No 1 Npatient 2 ER/Outpatient 3 DOA ျပ 4 \(\Bigcap \) Nursing Home 5 \(\Bigcap \) Residence 6 \(\Bigcap \) Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred FISHER, the Hospital or Attending thin 24 hours after death. Natural iniury work?
1 Yes 2 No 5 Pending Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Gertifying Nurse Practitioner: To the 29b. Signature and title of certifie 29d. Date signed (Month. Day. Year) DOG 63220 12/4 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GEORGE ISC 500 MPPER CHESAPEAKE DR., RELAIR M

State Registrar 31. Date filed (Month, Day, Year)

727 840000m

Annie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 40751 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month George J. Fales 2012 November 6:05 AM M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Joseph Richey Hospice Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Funeral 7. Age (In yrs, last birthday 9. Birthplace (State or Foreign Days Hours Country) Director 215-48-7133 1 X M 2 - F 63 Dec 28, 1948 Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6000 Bellona Avenue 21212 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 2 1 Never Married 2 Married 1 Yes 2 No unk 1 ☐ Yes 2 🕅 No Specify. Specify: white 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk unk (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other treumatic event, Item Me Elementary/Secondary (0-12) College (1-4 or 5+) unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOseph Richey Hospice 828 N. Eutaw Street Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 90121 4 ☐ Donation 5 ☑ Other (Specify) in state 21. Signature of Funeral Service Licens 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Director 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ ongestive disease or condition resulting in death) years Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examin attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Pregnant at time of death Day within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached it a | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic obstructive pulmonary 1 Yes 2 No 3 Probably 4 Unknown Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hospital or Attending Physician: The I
 Hours after death.
 Funeral Director: After this certificate h 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 2 Accident 5 Pending Investigation 1 Yes 2 No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practitions: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D51788 MN 11-30-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Polk # 300 Baltimore MD 21209 Falls 6115 Im

State Registrar 31. Date filed (Month, Day, Year) DEC 1 7 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	e or Marylan	Cer	tificate of i	Death	i and iv		Reg. No.)12	40752
	Physicia		1. Decedent's Name (First, Middle, Last) Salvatore Camino Galla	ai					2. Date of Dea Month	Day	Year	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give street and			4b. City, Town, c		n of Death	Decembe	4c. Coun	ty of Death	10:30 A ^M
_	-		43 Torque Way 5. Social Security Number 6. Sex	7. Age (In yrs. I	act hirthday)	Midd If Under 1 Year		ver	8. Date of Birt		altimo	ore place (State or Foreign
	Funeral Director		040 26 8013 1 🛣 M 2 🖸		Yrs.	Months Days	Hours	Min.	(Month, Day	v, Year)	Coun	necticut
	nd ihow at	'n	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ation	L					10d. Inside City Limits
	Maryla 28a-f s otified	Director	Maryland Baltimore		Middle	e River						1 ☐ Yes 2 🔀 No
	ith the	ral D	10e. Street and Number 43 Torque Way			10f. Zip Code	220			10g. Citizen o		ntry?
	eath w	⊆	11. Marital Status 12. Was	Decedent Ever in U.S	S. 13. V	Vas Decedent of H		rigin? (Spe	cify Yes or No-	14. Ra	ace - Americ	
21215-0036	ırs after d ural", or i I Examin	by	1 Never Married 2 Married 1 If Yes	ed Forces? Yes 2 X No s, Give or Dates.		Yes 2 X No			Rican, etc.)		ack, White, of the state of the	
15-(72 hou In "nat Medica	Completed	15. Decedent's Education (Specify only highest grade compl		(Give i	lent's Usual Occup kind of work done O NOT use retired	during mo	ost of workir	ng	16b. Kind of	Business/Ind	dustry
212	within ygiene. ner tha t, the I		8	ge (1-4 or 5+)		Machinist				Ra	ilroad	Ī
Maryland	d be fileo Mental Hi arked otl		17. Father's Name (First, Middle, Last) Dominic Gallagi				I .	ther's Name	(First, Middle,	Maiden Surnar	ne)	
, Mar	nd 2 shou ealth and n 27 is m		19a. Informant's Name/Relationship (<i>Type, Print</i>) Marie Gallagi (Wife)	į	1	ng Address (Street Drque Way				-		Code)
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ★Burial 2 ← Cremation 3 ← Removal 4 ← Donation 5 ← Other (Specify)	f Ott-	emetery cren	sition (Name of natory or other pla ry Cemet	^{ce)} ery		3/2012	20c. Location	-	own, State Maryland
Balt	permit Depart Import any inj		21. Signature of Funeral Service Licensee	Afri Sr.		. Name and Addre Bruzdzins 1407 old			l Home venue E	P.A.	Maryla	and 21221
			23a. Part 1. Enter the disease, or complications, shock, or heart failure. List only one cause	that caused the deat on each line.	h. Do not ente	er the mode of dyir	ng, such a	s cardiac o	r respiratory arr	rest,		Approximate Interval Between Onset and Death
	Medical		Immediate Cause (Final disease or condition resulting in death)	e to (or as a consequ		EMEN'	1A				<u> </u>	Chock and Dodan
	Examiner	je.	Sequentially list conditions, b.		0							
	rted d ansit	Examiner	Cause (Disease or injury	e to (or as a consequ	ience oi):						1/4	
	cate be executed physician and s the burial-transit	al Ex	that initiated events resulting in death) Last	e to (or as a consequ	uence of):							
220	ficate by physics the t	l edical	d							1		
P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		in the past 12 months?	s, outcome of pregna Live Birth 2 Feta Pregnant at time of a Unknown	aldeath 3	Ectopic pregnan Other (specify) _	су				Date of delive	ery Day Year
, P.O	requires that the des been signed by the s should be detached	l by Pł	Part II. Other significant conditions contributing		-			rt I.	23e. Did to			ne cause of death?
ords	v requii s been should	olete	ity perpension	10000					24a. Was	an 24b	. Were autor	psy findings available
Rec	The law ate has page 2	Som	CURONARY ARTOR	1 OUER	びビ				autor perfo 1 ☐ Yes	nsy rmed? 2 No	death?	mpletion of cause of 2 No
ital	hysician: The lavinis certificate havi	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:			Loth	er.	eath (Check				
of V	ig Physer this neral d	te: To	27. Manner of Death 28a.	1 Inpatient 2 Date of injury (Month, Day, Year)	ER/Outpatier 28b. Time of injury	28c. Inju	ry at		me 5 🔀 Resid 28d. Describe h			2
ion	ttendir death. tor: Af the fu	Certificate:	2 Accident Investigation			M 1 _	Yes 2		2006 1 11 (6)			
Division of Vital Records,	al or A			Place of Injury - At ho building, etc. (Specify		ет, тастогу, опісе]	28f. Location (S City or Tow		ber or Hurai	l Route Number,
	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral	Medical	29a. Certifier 1 X Certifying Physician: To (Check only one) 3 Certifying Nurse Practit	e basis of examination	n and/or invest	igation, in my opini	on, death	occurred at	the time, date a	nd place, and c	due to the car	use(s) and manner stated.
	Voith Com		29b. Signature and title of certifier			29c. Licens				29d. Date sign	ed (Month, I	Day, Year)
	DV		30. Name and address of person who completed	cause of death (Item	23a) (Tyne. F		29	97		12	114/1	21237
	8		J. M. NIEHOFF	m 910	FRAM	JKLIN S	QUA	Re 01	2-205	ani	mari	= mo
	Stat Registra		31. Date filed (Month, Day, Year) DEC 1 7 2012	2. Registrar's Signa	par par	w						/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene_ For State Registrar 40753 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Willie E. Graham Physician/ 095/ A M 3 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ST. AGNES HOSPITAL N/A BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours 249-24-2174 Country) Director 1 □XM 2 □ F 89 Yrs 12/08/1923 Carolina Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director N/ABaltimore 1 XYes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 940 Harlem Ave. 21216 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) 8th College (1-4 or 5+) Construction Worker UNK Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Marie Woods Samuel Graham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3000 Towanda Ave. Baltimore, MD 21215 Pecola Manning (Sister) 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 12/17/12 On-Site Crematory 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21 Signatur of Funeral Service Cens ² Name and Address of Facility Own, Jr. Funeral Home PA 21217 2140 N. Fulton Ave. Balto., MD 23a. Part 1. Exfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. shock, of heart failu Immediate Cause (Final Onset and Death Physician/ Isease or condition esulting in death) Medical 31 xmouth Due to (or as a consequence of): Examiner hiselles Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Completed by Physician/Medical Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) Month Pregnant at time of death oums runeral unrector. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe After this certificate 1 ☐ Yes 2 ☐ No Yes **Division of Vital** 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 \square Pending work? 1 ☐ Yes 2 ☐ No Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year Luca 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. A. A.M. E. (CZ) N. Eccl. (AUC) A. Ahme 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 7 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav utchinson 1914100 Medical December 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2000 Hookins Social Security Number If Under 1 Year | If Under 24 Hrs. Funeral 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Director 217-86-4487 1 M 2 F 40 02/10/1972 Md. Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Md Carrol1 Sykesville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 904 Central Ave 21784 USA 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Was Decedent __... Armed Forces? 1 ☐ Yes 2 🛣 No 14 Race - American Indian ģ 1 Never Married 2 Married Black White etc. Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12vrs. Bus Driver Transportation traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Robert Duvall Donna Hetrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Duvall (Mother) 904 Central Ave. Sykesville, Md. 21784. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) County Cremation 12/16/2012 Sykesville.Md 21. Signature of Fune at Service Licens P.O. Box 195 Sykesville, Md. 21784. Chapel 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PSIS Physician, disease or condition resulting in death) Medical Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of thems.) Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease of injury that initiated events sician and burial-trans resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Medical Box 68760 the IF FEMALE Physician/ yes, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Day Year ed by the a 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed lipage 2 should be det þ 23e. Did tobacco use contribute to the cause of death? Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy this certificate 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: မှ To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this c completely filled in by the funeral dir 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier Hauste MD Occomber 12, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KAWTUBITA PATIL 1800 Baltimore, MD 21287 31. Date filed (Month, Day, Year)

OEC 1 7 State 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 15, 2012 Physician/ Joseph Anthony Harrigan 4:40 amM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilcrest Hospice Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Months Days Hours 220-05-0148 Director 1 XXM 2 □ F April 10, 1921 Maryland parmit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglane. Important if Item 27 is marked other than "natural", or Items 23a or 28e-f show eny jolury or other traumatic event, the Madical Examiner must be processed. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 XXYes 2 □ No Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A Funeral 21209 5516 Mattfeldt Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2xxx Married Completed by Army 1 ☐ Yes 2 🖾 No Specify: Specify: 3 Widowed 4 Divorced White WITT Year or Dates. 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Racetrack & Horse Training Jockey's Agent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Catherine McClay Francis Xavier Harrigan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Harrigan 5516 Mattfeldt Ave., Baltimore, Maryland 21209 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 D Burial 2 Cremation 3 Removal from State Dec. 18,2012 Baltimore, Maryland 4 Donation 5 Other (Specify) Parkwood Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland 21211 My D 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Gastric cancer disease or condition resulting in death) ecics Medical Examiner Due to (or as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir b Hospital or Attending Physicien: The law requires that the death cartificate be executed 24 hours after death.
Peners Director: After this cartificate has been signed by the attending physician and physician and s the burial-transif Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ☐ Yes 2 N 1 ☐ Yes 2 ☐ No Division of Vital å 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other: |₽ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the test of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number D0070635 Name and address of person who completed caus of death (Item 23a) (Type, Print) Charles St Sute 4105 Buthmore 40 21209 Pate! 01 2 31. Date filed (Month, Day, State Registrar DHMH 17 Rev 06-2011

ORIGINAL

12-09472 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 40756 State of Maryland / Department of Health and Mental Hygiene Lennox Gilbert Hood 1- For State Certificate of Death Reg. No. Registrar . Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day December 12, 2012 Year 2114 hrs **Medical Examiner** Lennox Gilbert Hood 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Howard Columbia 6261 Branch Beech If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director 217-86-0836 Country) MD 50 1 M 2 F 12/18/1961 Yrs Usual Residence of Decedent 10d. Inside City Limits A 10a, State 10b. County 10c. City, Town or Location 1 Yes 2 X No is 23a or 28a-f show be notified at once, Columbia Howard MD permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at one. rector 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6261 Branch Beech 21044 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 1 Yes 1 Yes 2 No specify: 3 Widowed 4 Divorced If Yes, Give Year Specify. White <u>م</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 Compl Interpreter Sign Language 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Ronald G. Hood Martha Irene Baugher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 307 Georgia Avenue, NE Glen Burnie, MD Susan D. Personett - cousin 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 12/14/2012 Hanover, MD remation Cntr of MD 4 Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service License Harry H. Witzke's Family FH Inc Colle - With 4112 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval 23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Retween Onset and /Medical Death aHypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Èxaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and lan/Medical AMENDED 23a, 27, per me, g936 2-1-13 sm X UNPENDED attending physician or use as the burial Box 68760, IF FEMALE 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b, Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy Live birth Month Year past 12 months? Pregnant at time of death Physici 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? certificate Yes 2 🗸 No 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 V Other: Scene ER/Outpatient 3 DOA this 1 Yes ို 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury After 28a. Date of Injury (Month, Day,Year) 27. Manner of Death 1 X Natural 1 Yes 2 No Pending death. 24 hours after death Funeral Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) determined (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 and manner stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) OCME December 13, 2012 30. Name and address of person who completed cause of death (Item 23a)

Registrar
DHWH 17 Rev 1/2001
OCME 2006

State

Russell Alexander MD.

ORIGINAL

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

CUIVIE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40757 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month /2-/3 5:58 P M Medical 4a. Facility Name (f not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death timore imonium Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 Year If Under 24 Hrs 8. Date of Birth Months 113-52-9039 Hours Min. (Month, Day, Year) Director 1 🗆 M 2 🖫 F 66 Yrs. item 27 is merked other then "neturel", or items 23e or 28e-f show other treumetic event, the Medical Examiner must be mutilised at 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits imore SEX 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pege 1 and 2 should be filed within 72 hours effer death with the Department of Heelth and Mentel Hygiene.
Importent: If Item 27 is marked other then "neturely" or Items 23e any Injury or other treumetic event, the Medical Examiner marked once. Funeral one 21221 1154 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. δ 1 ☐ Never Married 2 Married 21215-0036 1 Yes 1 ☐ Yes 2 ☑ No Specify. Completed Specify: Blac 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Binder Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) Tural Route Number, City or Town, State, Zip Code) 8 Occan Yusbana Baltimore, 20a. Method o Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other 4 ☐ Donation 5 ☐ Other (Specify) 12,20-2012 1; monium 21. Signature of Funeral Service Dicensee 22. Name and Address of Facility Varahn C- Greene Funeral Services 140155 or K 905 Ruad Ballimore, MD 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) LUNG CANCER Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): gned by the ettending physicien end be deteched for use es the buriel-trensit Hospitel or Attending Physicien: The lew requires that the death certificate be executed that initiated events Due to (or as a consequence of): signed by the ettending physicien Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, is certificete hes been sig director, pege 2 should l 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificete hes performed? Yes 2 No 2 🗆 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) HOSPICE ၉ 1 Yes 2 🕱 No n 24 hours after death. se Funerel Director: After this c pletely filled in by the funerel dir 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accider 5 Pending work? 1 Yes 2 No Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medica 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **TIP**letely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of ense number 30. Name and address person who completed cause of death (Item 23a) (Type, Print)

State

MORGAN,

TRACIE L.

31. Date filed (Month, Day, Year)

CRNP

DECEMBER

DHMH 17 Rev 06-2011

Registrar

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death December 4 2012 Physician/ Johnson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center MD Anne Arundei Annapolis 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min. Director 217-56-4848 1 M 2 F 72 Oct 26, 1940 Maryland Usual Residence of Decedent show 10c. City, Town or Location Director ems 23a or 28a-f sh r must be notified a Anne Arundel Edgewater 10e. Street and Number 10g. Citizen of What Country? Funeral 827 Mayo Road 21037 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. white 3 ₺ Widowed 4 □ Divorced Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Ò housecleaner private homes Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Page 1 and 2 should be 1 Maurice Hager Irene Sullivan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health airem 27 i 3853 Solomons Island Road Edgewater, MD 21037 Steven Johnson/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite any injury or oth 1 Durial 2 Cremation 3 Removal from State 4 □ Donation 5 ♥ Sther (Specify) in state Signature of Euneral Service Licensee

Ronald S. Wade Director 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 rt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest sh ck, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician/ Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Fes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 N 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work Investigation 6 Could not be 1 Yes 2 No Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifler 29d. Date signed (Month, Day, Year) R131937 Heather Adraws December 5 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

10d. Inside City Limits

Approximate Interval Betweer

Onset and Death

month

Dav

Year

1 Yes 2 No

6:25 pm

Registrar DHMH 17 Rev 06-2011

State

445

32. Registrar's Signature

Heather S. Travis 31. Date filed (Month, Day, Year)

Defense Hwy Annapolis Mb 21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 14 A M Month Physician/ MOSON Reember Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSACE BAHIMORE lowson Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8 Date of Birth Funeral 097-46-3199 Days Hours Director 1 M 2 D F 1955 NEW YORK me ol 27 is merked other then "neturel", or items 23e or 28e-f show traumetic event, the Medical Examinar must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 X Yes 2 ☐ No MARYLAND 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21225 USA Street Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status should be filed within 72 hours efter dend Mental Hygiene. Black, White, etc. Š 1 Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: TICAN /thesican 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Salvation ARMY æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jarian Elizabeth JOHNSON permit. Pege 1 and 2 should be Depertment of Heelth end Men Importent: If Item 27 is merke eny Injury or other traumetic. Johnson 19a., Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21325 SON - Day <u> Dhakeema</u> 5% 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State gemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State till Cemetery inden Lew Jersey 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wo FRANKlin 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ multiple Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of). To the Hospital or Attending Physicien: The lew requires that the death certificate be executed within 24 hours efter death.

To the Funerel Director: After this certificate hes been signed by the ettending physicien and burlal-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 use es the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 menths?

1 Yes 2 X No
9 Unknown ō Month signed by the eight g Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown cate hes been sig ; pege 2 should b 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: 1 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) completely filled in by the funeral 27. Manner of Death Certificate: 28d. Describe how injury occurred 28c. Injury at Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. (haples 31. Date filed (Month, Day, Year)
NEC 1 7 2012 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

12-09405 George Kelly Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible.

	State of Maryic 1- For State Registrar	Certificate of	i Health and Mental Hy i Death		012 40760			
Physician/	Decedent's Name (First, Middle,Last) Geor	ast) George Samuel Kelly Jr. 2. Date of Death 3. Time of Dea						
Medical Examiner	George S. Kelly, Jr 4a. Facility Name (if not institution, give street and not institution).		4b. City, Town, or Location of Death	December 10, 2012	1626 hrs			
	1100 Webb Court Apartment #1	V	Baltimore		N/A			
Funeral Director	5. Social Security Number 579-72-1407 6. Sex	7. Age (In yrs. last birthday) 55 Yrs	If Under 1 Year If Under 24Hrs. Months Days Hours Min.		7Y) 9. Birthplace (State or Foreign D • C •			
ny	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Locati	on		10d. Inside City Limits			
Aaryland 28a-f show any Latonce. ector	MD N/A	Baltimore			1 X Yes 2 No			
the Maryland n or 28a-f sh iffed at once Director	10e. Street and Number		10f. Zip Code	10g. Citizen of	What Country?			
th the 23 or soutified	1100 Web Court		21202		U.S.A.			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	1 Never Married 2 Married Armed F	orces? If Y	s Decedent of Hispanic Origin? (Spes, specify Cuban, Mexican, Puerto	Rican, etc.) WI	ace - American Indian, Black, hite, etc.			
tural",	Widowed 4 Divorced If Yes, Give Yes 15. Decedent's Education (Specify only highest gra	de completed) 16a. Deceden	Yes 2 X No specify: t's Usual Occupation (Give kind of w		y: Black Business/Industry			
6 172 hou an "na ical Exa	Elementary/Secondary (0-12) College (1-4 or 5+) during m	ost of working life. DO NOT use retir cation	red)	imore City			
-003 I withir grene ther th e Medi	12th 17. Father's Name (First, Middle, Last)	Sanit		(First, Middle, Maiden Surnar	_			
MD 21215-0036 42 should be filed within 7 th and Mental Hygiene. n 27 is marked other than numatic event, the Medica To Be Complé	George S. Kelly, Sr		Elizab	eth West				
MD 21 2 should 2 should 27 is ma matic cv	19a. Informant's Name/Relationship (Type, Print) Madora Kelly (Daught		Address (Street and Number or F Riggs Ave. Ba					
re, I	20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal #	crematory or oth	ition (Name of cemetery, ner place)		on - City or Town, State			
Baltimore, permit. Pages I ar Department of Hei Important: If ite	4 Donation 5 Other Specify:	On-Site	Crematory 12/					
Ball permit Depart Impor	27. Signature of Funeral Service Licenses		josephessmisrow 40 N. Fulton A					
Physician /Medical	23a. Part I. Enter the disease, or complications that of failure. Use only one cause on each line.	aused the death. Do not enter the	ne mode of dying, such as cardiac or	respiratory arrest, shock, or	Between Onset and			
Examiner		sclerotic Card	lovascular Diseas	se	Death			
L	Sequentially list conditions, if any, leading to immediate b. Due to (or as a	a consequence of):						
ted Insit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated							
d ansit	events resulting in death) Last Due to (or as a	a consequence of):						
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and appletely filled in by the funeral director, page 2 should be detached for use as the burial - transit lical Certification: To Be Completed by Physician/Medical Exi			ne,g937 3-13-13 s	5 m				
876(inficate ng phys as the b	23b. Was decedent pregnant in the	outcome of pregnancy pirth 2 Fe	tal death 3 Ectopic pregna		of delivery Day Year			
). Box 68760, the death certificate be by the attending physici thed for use as the buring Physician/Med	past 12 months? 1 Yes 2 No 9 Unknown g Unkn	nant at time of death 5 Ot	her (Specify)		,			
that the detected the detached the	1	o death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobacco use co	ntribute to the cause of death?			
, P.(1 Yes 2 No	3 Probably 4 V Unknown			
Records, The law requires ficate has been sig , page 2 should be Completed				autopsy	b. Were autopsy findings available prior to completion of cause of			
Reco				performed? 1 ✓ Yes 2 No	death? 1 ✔ Yes 2 No			
Vital Recysician: The 1 bis certificate 1 director, page o Be Corr	25. Was case referred to medical examiner? Hospital:		26.Place of Death (Check of Other Nursin					
n of Viding Phys I. After this funeral di	1 Yes 2 No 28a. Date	Inpatient 2 ER/Outpatient of Injury 28b. Time of I	o Box 4 Naroni	g Home 5 Residence 6 28d. Describe how injury occ	Other: Scene			
lending sath. or: Al	Natural 5 Pending	ı, Day,Year)	Yes Z NO					
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that th within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be deated ledical Certification: To Be Completed by P	3 Suicide 6 Could not be 28e. Plac	e of Injury - At home, farm, stree	et, factory, office building, etc.	28f. Location (Street and Nur or Town, State)	mber or Rural Route Number, City			
To the Hospital within 24 hours To the Funeral completely filled	29a Certifier		red at the time, date and place, and	due to the cause(s) and man	ner as stated.			
To the How within 24 by To the Funcompletely		of examination and/or investigat	ion, in my opinion, death occurred a					
, N	29b. Signature and title of certifier		29c. License number		igned (Month, Day, Year)			
(A)	7 Keodre M. Ky	of TR. m.D.	O.C.M.E.	December	er 11, 2012			
	 Name and address of person who completed cau Theodore M. King, Jr., MD. Assista 	-750	900 W. Baltimore Street, Ba	altimore, MD 21223				
State Registrar	31. Date filed (Month, Day, Year)	egistrar's Signature	2					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #17. Per ANA BD G935 1/10/2013 III and Mental Hygiene

AMEND #4c Per ANA BD G935 1/14/2013 JH For State Registrar amend #10b Per ANA BD G935 Peringate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 6:32 AM M Frederick E. Kerstetter Jr November 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Worcester **Examiner** 12949 Center Drive Ocean City Dorchester Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days (Month, Day, Year) Hours 218-40-5699 Director 1 🔀 M 2 🗆 F Mar 11, 1943 69 Maryland Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Worcester 1 Yes 2 No MD Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21842 12949 Center Drive USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: If Yes, Give Year or Dates Specify: white 61-64 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12 plumber self employed Be 17. Father's Name (First, Middle, Last) **Elwood Frederick Elwacod** Kerstetter Sr 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev မ Ruth Marie Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elfriede Kerstetter/spouse 12949 Center Drive Ocean City, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) Signature of Funeral Service I 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the bur Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 X. Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 Yes Yes 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 1 Natural 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pendina work? 1 ☐ Yes 2 ☐ No. Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my animal and the state of the cause of t Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29h 29d. Date signed (Month, Day, Year) D26278 POBOX 1733 Salabu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COASTAL HUSPIKE State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1- For State Registrar	f Maryland / Depa <i>Cer</i>	rtment of tificate of		F	Reg. No.	2 4076
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) Kenneth Leroy Ki	rtz III			2. Date of De Month December	ath Day Year er 13, 2012	3. Time of Death 0718 hrs
	4a. Facility Name (if not institution, give s I 195 Eastbound exit 47	street and number)	4	b. City, Town, or Loca Arbutus		4c. County of Deat Baltimore Co	
Funeral Director	5. Social Security Number 6. Sex 12-37-5686	7. Age (In yrs. la	ast birthday) Yrs.		lours Min	irth(MM/DD/YYYY) 9. Bi Forei 14,1992	
show any ace.	Usual Residence of Decedent 10a. State Md. Harford		Town or Location Joppa	on			10d. Inside City Limits 1 Yes 2 X No
r death with the Maryland or items 23a or 28a-f sho must be notified at once Funeral Director	10e. Street and Number 230 Spry Island R	d.		10f. Zip Code 21085	1	10g. Citizen of What Cou USA	Intry?
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "matural", or items 23a or 28a-f she static event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced If	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No Yes, Give Year	If Ye		origin? (Specify Yes or Nican, Puerto Rican, etc.)	o- 14. Race - Amer White, etc. Specify: Wh:	ican Indian, Black,
215-0036 be filed within 72 hours after hed other than "natural", rised other than "natural" ent, the Medical Examiner Be Completed by	15. Decedent's Education (Specify only Elementary/Secondary (0-12) 1 yrs.	r Dates: highest grade completed) College (1-4 or 5+)		s Usual Occupation (0) st of working life. DOI		16b. Kind of Business,	-
21215-0036 Juld be filed within 7 Mental Hygiene. Marked other than te event, the Medica TO BE Comple	17. Father's Name (First, Middle, Last) Kenneth Leroy K			М	other's Name (First, Middle, elonie Rae W	ood	
	19a. Informant's Name/Relationship (Typ Melonie Romans	e, Print) mother			Number or Rural Route Nu Rd. Joppa M.		e, Zip Code)
Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2 injury or other traum	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other Specify:	Removal from State Ba	Place of Disposit crematory or other YVIEW C	tion (Name of cemeter er place) rematory	Dec 18 2012	20c. Location - City of Baltimore	Town, State
Balti permit. Departi Import injury	2). Signature of Funeral Service Lien e	7	1/11	o Somers .	ral Home Of 1 Point Rd. 21	1.1.1.	
Physician Medical sxaminer		ations that caused the death. Iline. ultiple Injuries ue to (or as a consequence of		e mode of dying, such	as cardiac or respiratory ar	rest, shock, or heart	Approximate Interval Between Onset and Death
ted Insit	cause. Enter Underlying Cause	ie to (or as a consequence of					
so, te be executed ysician and burial - transit	d. UNPENDED	AMENDED					
lox 6876 leath certifical attending ph for use as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregr 1 Live birth 4 Pregnant at time of dea	2 Feta	al death 3 Ec	topic pregnancy	23d. Date of deliver Month	y Day Year
, P.O. B res that the de signed by the be detached in d by Phy	Part II. Other significant conditions	ontributing to death but not re	esulting in the un	nderlying cause given i		tobacco use contribute to	
of Vital Records, ag Physician: The law requires through the base significant director, page 2 should be not To Be Completed					24a. Was auto perfc 1 ✓ Yes	psy prior to or death?	utopsy findings available completion of cause of
Vital Recysician: The his certificate director, page	25. Was case referred to medical examiner?	spital: 1 Inpatient 2	ER/Outpatient	- iOthor	eath (Check only one)	Residence 6 🗸 Othe	r: Scene
ion of Vi tending Physicath. tor: After this the funeral dir	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year) Dec 13, 2012	28b. Time of In 0705 hrs	jury 28c. Injury at V	Driver auto	how injury occurred involved in auto ac	cident
Division o spital or Attending nours after death. neral Director: Aft filled in by the fune Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho (Specify) Interstate/E		i, factory, office buildin	or Town,	(Street and Number or Ru State) und exit 47, Arbutus, N	
Di To the Hospital within 24 hours a To the Runeral completely filled	one) 2 Medical Examiner: C	 To the best of my knowledg In the basis of examination are In manner stated 		on, in my opinion, deat	h occurred at the time, date	and place, and due to th	e cause(s)
) ž	29b Signature and title of certifier	9		29c. License num O.C.M.E.	nber	29d. Date signed (Mo	
	30. Name and address of person who con Ling Li, MD Assistant Med	mpleted cause of death (Item dical Examiner 900 \		e Street, Baltimor	re, MD 21223	•	
State Registrar	31. Date filed (Month, Day, Year)	3. Registrar's Signatur	face	1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item per fh g934 12-21-12 vt. State of Maryland Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1 1 ay 20^{Year}2 Deborah Vanessa Lewis 3:50 рМ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford 1411 Bayview Drive Havre De Grace Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9 Birthplace (State or Foreign **Funeral** 55 Yrs. Hours 0/40/t/2 Pgy/ 199 57 MD 217-70-1071 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County ms 23a or 28a-f shormust be notified at 10c. City. Town or Location 10d. Inside City Limits Director Harford Havre De Grace MD 1 🗌 Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 1411 Bayview Drive 21078 er than "natural", or items the Medical Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 XNever Married 2 Married by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working 2 should be filed within 72 th and Mental Hygiene. life DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Harford City Govt. Civil Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vernell David Lewis, Sr. Annie Mae Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or all 2112 Fernglen Way, Catonsville, MD 21228 Alex Lewis (Brother) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 X Removal from State 12/17/12 Lewis Cemetery Crew, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lic-^{22.} Name and Address of Facility Joseph H. Brown Jr. Funeral Home PA Þ 2140 N. Fulton Ave. Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Phyllician/ une disease or condition Medical resulting in death) Due to (or as a co **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examir Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physiciar Physician/Medical certificate be Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death the 9 Unknown signed by the Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\sum \) Yes 2 \(\sum \) No 24a. Was an has autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate Yes filled in by the funeral director, 25. Was case referred to medical Hospital or Attending Physician: 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

H. TOYOPE KINS 500 Upper (MD 21014

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Mort)

Deborah

32. Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Alberta Leatherwood ELEMBER 10.2012 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BURNIE AMNE SALTIMORE WASHINGTON MEDILAL CENTIFIC 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Director 219-26-8049 1 □ M 2**X** F 78 Mar 30, 1934 Maryland Usual Residence of Decede or 28a-f show with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Odenton 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 457 Monterey Avnue 21113 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: white Completed 3 XWidowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) real estate agent properties Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Albert Monroe Tawney Rose Feighnne 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) In portant: If item 27 is Jacklyn K. Young/daughter Baltimore, M 119 Poplar Street P.O. Box 533 Secretary, MD 21664 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 X Donation 5 Other (Specify) Signature of Sar eral Sarvice ensee Wade State and Address of Facilities Board 655 W. Baltimore Street Baltimore, MD 21201 Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ THEUMON14 Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Dav Year 2 No the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed? Yes 2 No 1 🗌 Yes 2 No Hospital or Attending Physician: 7 24 hours after death. Funeral Director; After this certifice 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred ✓ Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examîner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Sign me and address of person who complete rive Glen Burne eted cause of death (Item 23a) (Type, Print nospital . Date filed (Month. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical Day 7:30 December 12 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hospital of Baltimore Baltimore City If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Funeral 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Elizabeth Town 68 1 MM 2 □ F Director or 28a-f shov 10c. City, Town or Location death with the Maryland any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits **Funeral Director** 1 Yes 2 No 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a 3914 Noyes Circle Apt. 202 2/13 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Dever Married 2 Married 1 V Yes 2 No If Yes, Give Year or Dates. permit. Page 1 and 2 should be filed within 72 hours after 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) Patient Known 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of gemetery, crematory or other place) ■ Burial 2 □ Cremation 3 □ Removal from State 12-21-12 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility VAUGHN C. 8728 Liberty Rd. RANDA 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ Acute Entra Cerebral Homenhan Secondary to C disease or condition resulting in death) Medical Due to (or as a consequence of) 3 days Examiner Stroke Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Severe Heart failure with Lew EF attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ity pertension within 24 hours after death.

To the Funeral Director: After this certificate has been sit completely filled in by the funeral director, page 2 should I 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Consestine Heart Failure Drabetes mellitus 24a. Was an perform 25. Was case referred to medical examiner?

1 Yes 2 No æ 26. Place of Death (Check only one) Other: 4 \(\subseteq \text{ Nursing Home } 5 \subseteq \text{ Residence } 6 \subseteq \text{ Other (Specify)} Hospital: မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Yertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) December 12, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rupinder Singhi Sinai Itesprita 31. Date filed (Month_Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Raymond J. Littleton Medical November 2012 7:30 PM M 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Joseph Richey Hospice Baltimore Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Davs Hours Min. (Month, Day, Year) **Director** 217-52-3124 1 □XM 2 □ F 62 Yrs. Usual Residence of Deceden Dec 14, 1949 Maryland 10a, State 10b. County 10c. City, Town or Location with the Maryland ir than "natural", or itams 23a or 28a-f sho the Medical Examiner must be notified at Director 10d. Inside City Limits MD Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4300 Mary Avenue 21206 USA within 72 hours aftar daath 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. ğ 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: 3 Widowed 4 Divorced Completed Specify: white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) parmit. Paga 1 and 2 should ba filad wit.
Department of Health and Mantal Hygian
Important: If item 27 is marked other t.
any injury or other traumatic event, the laborer construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harry Littleton Mary Carol Samborski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Richey Hospice 828 N. Eutaw Street Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Ronard 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 a/de A Director 23a. Ptt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, suck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) onces months Medical Due to (or as a consumence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury Due to (or as a consequence of): tha attanding physician and thad for usa as tha burlal-trar that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year ed by tha a datachad 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To the Hospital or Attanding Physician; The law raquiras t within 24 hours after death,

To the Funaral Director: After this cartificate has been sign completely filled in by the funaral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 No ☐ Yes 2 🗖 No 25. Was case referred to medical examiner? Be Division of Vital 26. Place of Death (Check only one) မ 1 ☐ Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation ☐ Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar only one)

29b. Signature and title of certifier

29-12

Raymond Littlebu

MO

6115

Falls Kd

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

POIX

Im

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

751788

Baltimore MD 21209

11-30-12

29c. License number

2 Medical Examiner: On the pasts of examination analysis investigation, in this plant, in this plant, date and place, and due to the cause(s) and manner as stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

#300

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40767 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 99, 2012 06:18 A_M Emma Maynard Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3813 Stepping Stone Lane Burtonsville Montgomery Social Security Number If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 169-14-1292 (Month, Day, Year) Director 1 □ M 2 □ F 92 April 4,1920 Pennsylvania Usual Residence of Deceden Show should be filed within 72 hours after death with the Maryland end Mental Hygiene. Is marked other then "natural", or items 23e or 28e-f sho eumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Montgomery Burtonsville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3813 Stepping Stone Lane 20866 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☐ No \$ 1 Never Married 2 Married Black, White, etc. Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Completed 3 X Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home other treumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Fiss Mary Astheimer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sha Depertment of Health en Important: If item 27 is any Injury or other treu once. Charolette Maynard (Daughter) 3813 Stepping Stone Lane Burtonsville, Md. 20866 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 → Burial 2 Cremation 3 N Removal from State Limerick Burial Grnds 12/14/2012 Limerick, Pa. 19468 4 Donation 5 Other (Specify) Signature of Euneral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. Talbott Avenue, Laurel, Maryland 20707 M01196 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition -Physician/ Cardiac Arrythmia 5 Min Death Medical resulting in death) Due to (or as a consequence of): ∕Examiner Coronoary Artery Disease 30 yrs. Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the attending to the property of the property the attending physician and ched for use as the buriel-transit Hypertensive Heart Disease Cause (Disease or injury that initiated events 40 yrs. resulting in death) Last Due to (or as a consequence of) Physician/Medical Chronic Obstructive Pulmonary Disease Division of Vital Records, P.O. Box 68760 10 years IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month been signed by the a should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed this certificate has been si aral director, page 2 should 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Diabetes Mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Renal Disease 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death ieral Director: After i filled in by the funera 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending Investigation 1 ☐ Yes 2 ☐ No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Framiner: On the basis of examination and/or investigation in my opinion, death accurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Descripting Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 06-2011 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Vivek C. Vaid, M.D.,

DEC 1 7

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

3311 Toledo Terrace, #B102, Hyattsville, Maryland 20782

D17843

29d. Date signed (Month, Day, Year)

December 09, 2012

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 ar Dec. 1.3^{ay} Mary Love Mezzanotte Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 13337 Pipes Lane Sykesville Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 Zone 7. Age (In yrs. last birthday) **Funeral** 264 82 8822 Director 1 □ M 2 🕱 F 04/13/1956 Panama Canal 56 Usual Residence of Decede 28a-f show 10a. State 10c. City, Town or Location at Funeral Director other traumatic event, the Medical Examiner must be notified Howard Sykesville MD 10e. Street and Numbe 10f. Zip Code 6 10g. Citizen of What Country? 23a United States 13337 Pipes Lane 21784 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. þ ō 1 Never Married 2 X Married 1 Yes 2 No If Yes, Give 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: "natural", Completed White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed Attorney Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, and Mental | ၉ M. Joan Love Leo H. Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 13337 Pipes Lane Sykesville, MD 21784 Albert Mezzanotte/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 Department of Important: If it any injury or conce. 1 Burial 2 Cremation 3 Removal from State Crest Lawn Mem. Gard. 12-18-2012 | Marriottsville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facilit Harry H. Witzke's Family FH Inc. Shen Collins -4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) olon cana Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ☐ Live Birth 2 ☐ Feed acts
☐ Pregnant at time of death
☐ Unknown in the past 12 months? Month been signed by the a should be detached 1 Yes 2 No 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖟 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Hospital or Attending Physician: The 24 hours after death. Funeral Director: After this certificate I Yes 2 X 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 4 Nursing Home 5 X Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DDA 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Accident X Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Dec. 14, 2012 MD on who completed cause of death (Item 23a) (Type, Print) 30. Name and addr reene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

40768

3. Time of Death

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

2 No

1000

Year

1 🗌 Yes 2 🔀 No

7:00 р м

Registrar DHMH 17 Rev 06-2011

State

32. Registrar Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar 40769 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Anthony J. Mastradone 10:20am December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sunrise Assisted Living Silver Spring Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Director 232-26-9898 1**X** M 2 □ F 94 09/10/1918 West Virginia Usual Residence of Decedent 10a. State 10b. County items 23a or 28a-f sho her must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Delaware. Sussex Lewes 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 303 Tanglewood Drive 19958 U.S.A. illed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner 1 Never Married 2 Married Black, White, etc. ۾ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 Divorced Specify: Completed WWII White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) District of Columbia Mechanic Government event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H is marked of permit. Page 1 and 2 should be filt Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve Camella Santucci Larry Mastradone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 303 Tanglewood Drive, Lewes, Delaware 19958 Ann Mastradone - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) 12/17/2012 Silver Spring, MD Gate of Heaven Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home. 11800 New Hampshire Ave.,Silver Spring,MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory in a shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year signed by the a Id be detached f 9 Unknown 9 Unknown Part II. Other significant conditions uting to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ② No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has to funeral director, page 2 to performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes မ 218 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Al
completely filled in by the fu 2 Accident
3 Suicide М 1 🔲 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of any knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title 29d. Date signed (Month, Pay, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Seth Eaton, M.D., 7350 Van Dusen Road, Maryland 20707 Laurel.

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Maryla	ind / Dep	artment of H	ealth and	Mental Hy	/giene		
			1 - State Registrar		rtificate of D	eath eath	Reg. No. 20 2 4 0 7 7 0				
	Physicia Medi		1. Decedent's Name (First, Middle, L LAWREN CE	MARSHAL	L			2. Date of Do Month		Year 2012	3. Time of Death 5.05 Ru
-	Examir	ner	4a. Facility Name (If not institution, g. MERCY MED) (4b. City, Town, or BALTI	Location of Death	E	4c. County	of Death	
	Funeral Director		231-40-1269	Sex 7. Age (In yrs 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di		Count	olace (State or Foreign try) inia
	yland f show ed at	tor	Usual Residence of Decedent 10a, State 10b. County	10c. (City, Town or Lo	eation		вере 2	3. 1330		0d. Inside City Limits
	Mar. 28a- ootifie	Director	MD		Baltim-						1 X Yes 2 □ No
	ith the		10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Coun	try?
	ems 2	Funeral	524 N. Charles 11. Marital Status	Street #1010	IS 13 3	21201 Was Decedent of His		pecify Ves or No.	US 14 Pers	- America	on Indian
21215-0036	rs after de ıral", or itu Examine	by	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?		If Yes, specify Cuban	, Mexican, Puert			, White, e	
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12	/ithin / iene. r than the M	Con	Elementary/Secondary (0-12) unk	College (1-4 or 5+)	life. D	O NOT use retired)					
b	lled w I Hyg othe /ent,	Be	17. Father's Name (First, Middle, Last			firemar unk		ne (First, Middle	Pub : , Maiden Surname)	lie s	unk
ylar	uld be f Menta narked atic ev	욘							·		unk
Maryland	d 2 shou alth and 27 is m ir traum		19a. Informant's Name/Relationship Jim Williams/fr			ng Address (Street ar N. Charle					
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 🔣 Other (Spe	□ Removal from State cify) in state	Place of Dispo cemetery, cren	osition (Name of matory or other place		Date	20c. Location - 6		
Balt	permit. Depart Import any inj once,		21. Sign for Funeral Service ice	Wate Directo		Name and Address tate Anato	my Boar	d 655 W	. Baltimo	re S	treet
			23a. Part 1. Enter the disease, or co shock, or heart failure. List only	mplications that caused the de-	ath. Do not ente	er the mode of dying,	such as cardiac	or respiratory ar	rrest,		Approximate Interval Between
200,	Medical		Immediate Cause (Final disease or condition resulting in death)	a. GROUP G Due to (or as a conse	quence of):	Tococy			MIA		Onset and Death
	Examiner	<u>.</u>	Sequentially list conditions,	b. Right low	er EXI	remity	celluli	tis			
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09	cate be executed physician and s the burial-transit	dical E	resulting in death) Last	Due to (or as a conse	quence of):						
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Box 687	Ione hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Birector After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregr 1 Live Birth 2 Fe 4 Pregnant at time of 9 Unknown		23d. Date Mon		ry Day Year			
ds, P.O.	fuires that I	ed by P	Part II. Other significant conditions	contributing to death but not re	esulting in the u	nderlying cause give	n in Part I.		Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown		
Division of Vital Records,	sician: The law red s certificate has ber director, page 2 sho	Completed						24a. Was auto perfo	utopsy prior to completion of cause of death?		
<u>ta</u> .	cian: ertific ector,	Be	25. Was case referred to medical examiner?	Hospital:			e of Death (Chec				
<u> </u>	Physi this o	은	1 Yes 2 No 27. Manner of Death	1 Inpatient 2	ER/Outpatien				dence 6 🗆 Other		
o uc	nding tth. : After e fune	cate	1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	injury	28c. Injury a work? M 1 🗆 Ye	at es 2 □ No	28d. Describe I	now injury occurred		
Divisio	to the hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	l Certificate:	3 Suicide 6 Could not determined	be 300 Blood of Injury. At h		eet, factory, office			in (Street and Number or Rural Route Number, Town, State)		
	n 24 hour n 24 hour ne Funera oletely fill	Medical	(Check 2 ☐ Medical Exar	ysician: To the best of my knowniner: On the basis of examinations of examinations of examinations of the best of	on and/or invest	igation, in my opinion.	death occurred a	t the time, date a	and place, and due t	o the caus	se(s) and manner stated
	Northi Com	_	29b. Signature and title of certifier	En MD		29c. License n			29d. Date signed (
			30. Name and address of person who	completed cause of death (Item	m 23a) (Type, P	rint)		aul Pla	ce Ball)mo	re MD 21202
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Patricia Maloney December 4:30 PM Michel Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll LookAbout Manor Westminster 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Hours Director 215-30-4495 1 🗌 M 2 🔀 F 81 Yrs. Aug. 29, 1931 Maryland th and Mental Hygiene. 27 is marked other then "naturel", or items 23e or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 Yes 2 No Maryland Carroll New Windsor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1914 Old New Windsor Rd. 21776 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) legal secretary law_practice Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file of Health and Mental Firem 27 is marked o ဂ္ Michael Michel Marjorie Hopkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Patrick Maloney/son 2736 Littlestown Pike Westminster, MD 21158 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of F
Important: If ite
any Injury or ot Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery: 12/15/2012 Pikesville, MD Signature of Funeral Service Lice 22. Name and Address of Facility Hartzler Funeral Home, P.A. (atharine 310 Church St. New Windsor, MD 21776 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) DARKWYCH'. DISCUR Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the humal themost Cause (Disease of itijury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 \square Yes 2 \square No 3 \square Probably 4 \square Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be (**Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Ving ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12-12-12 Duzuuz 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TE. 14 21787 treebench TRNEUTOWN 31. Date filed (Month, Day, Year) State 1 7 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Louis Vincent Myers, Jr. 10 10:30P M <u>December</u> 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Northampton Manor Frederick Frederick Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months (Month, Day, Year) Director 1 1 M 2 □ F 220-09-8212 95 Yrs. Sep. 19, 1917 Maryland Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23e or 28a-f showeny Injury or other treumetic event, the Mexical Evantinar must be a culfied at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11054 Bennie Duncan Rd. 21701 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 X Yes 2 No Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1941–45 1 ☐ Yes 2 🔀 No Specify: Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) plumbing & heating plumber Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဨ Louis V. Myers Sr. Mary Margaret Sappington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Myers/ wife 11054 Bennie Duncan Rd. Frederick, MD 21701 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 K Burial 2 Cremation 3 Removal from State St. Peter's Cemetery 12/14/2012 Libertytown, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Hartzler Funeral Home, P.A. athon 11802 LIberty Rd. Libertytown, MD 21762 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DISEASE-MITERY Physician/ ORONARY disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner DNEUMONIA Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami g physicien end es the buriel-trensit or Attending Physician: The law requires thet the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 ettending p IF FEMALE: nse yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) ed by the e 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? q Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed Yes 2 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: 1 🗌 Yes ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Division 1 Yes 2 No Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2/ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 4795 12-12-2012 lm 2 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

122 - A KATMI, MN SIY TOIL HOUSE AVE MEDERICK,

DHMH 17 Rev 06-2011

State Registrar

P.O.

of Vital

32. Registrant Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December Peggy Jean Moore 07:14 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Agnes
Social Security Number Hospita salfimore If Under 1 Year If Under 24 Hrs 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth (Month, Day, Year) Director 214-54-5249 1 □ M 2 🔀 F 63 December 30, 1948 Maryland Usual Residence of Deceder than "natural", or items 23a or 28a-f show the Macical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 ☐ Yes 2 🙀 No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 908 Niagara Court 21227 <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: White Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemakeı Own Home Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F ပ William Edson Lorena Smoot permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence Moore/Husband 908 Niagara Court, Baltimore, Maryland 21227 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pi 20c. Location - City or Town, State December 14. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State injury or West Arundel Crematory 4 Donation 5 Other (Specify) 2012 Odenton, Maryland 21. Signature of Funeral Service Licensee Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road, Odenton, Maryland 21113 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ iente myseard disease or condition Medical resulting in death) Due to (or as a consequent of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events southing in death) Leat. iner Due to (or as a consequence of) Exami sate hes been signed by the attending physician and page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 줍 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No this certificate ✓ Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Moore, Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 힏 1 🗌 Yes , 2 🗹 No ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 5 Pending Natural work? 1 ☐ Yes 2 ☐ No death. ☐ Accident Investigation 24 hours after deat Funeral Director: 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospitai Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 3 🗌 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1/AM ST KINESHESP ITAL 31. Date filed (Month, Day, Year) State

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Registrar

DEC 1 7 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Aguilar Leslie Pasion 4:20 December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 9 Cedar House Court Baltimore Rosedale 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 216-51-1174 Director 1 ☑ M 2 ☐ F 65 Dec 17 1946 Philippines permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene any injury or other traumatic event, the Medical Examiner 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Baltimore Rosedale 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? 21237 **USA** 9 Cedar House Court 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Force Black, White, etc. by 1 Never Married 2 X Married 1 ☐ Yes 2 ☒ No If Yes, Give 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: Filipino Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Environmental Aide Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Juana Aguilar Basilio Pasion 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucita Pasion/ Wife Cedar House Court Rosedale, MD. 21237 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-19-12 Hilltop Service Co. Towson, MD. Signature of Funeral Service License 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson. 23a. Part 1. Inter the distriction or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as consequence of): or Attending Physician: The law requires that the death certificate be executed ig physician and as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ours after death.

eral Director: After this certificate has I filled in by the funeral director, page 2 s autopsy performed? Yes 2 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 DONO မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Medical Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely fi 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

mas Samue		1- For State Certificate of Death Reg. No. 2	012 4077
Physici dical Exami			3. Time of Death ear 0439 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County	y of Death
		University Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYY	ON O Birthmiana (State as
Funeral Director		215-21-4189 1 DM 2 F 24 Yrs. Months Days Hours Min. 7-22-1988	Foreign MARYLand
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
A .	ō	5 Wd Bactimore	1 Yes 2 No
Maryl r 28a-f ed at o	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of V	
with the Maryland ns 23a or 28a-f sho be notified at once.			517
5-0036 ed within 72 hours after death with the Maryland lygiene, other than "natural", or items 23a or 28a-f she other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rac Wh	ce - American Indian, Black, lite, etc.
after c	by F	3 Widowed 4 Divorced it res, sive Year 1 Yes 2 No specify: Specify Specify:	Black
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MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 127 is marked other than umatic event, the Medica		T7. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surnam	ne)
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MD 2 12 shou th and b 27 is n	F	Brenda Stinner 2030 N. Washington Stree	
2 72 8 8		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location	n - City or Town, State
Baltimore, Dermit. Pages I at Department of He Important: If ite		1 Burial 2 Cremation 3 Removal from State Bayon Tabour or other place) 4 Donation 5 Other) Specify: Bayon Tabour or other place) 10/22/12 Bayon Tabour or other place)	to, Md.
Baltimo permit. Page Department o Important: injury or oth		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Miller 3 Me Ligot	
Physician		23a. Part / Enter the disease, or complications that caused the death. Do not effer the mode of dying, such as cardiac or respiratory arrest, shock, or h	neart Approximate Interva
/Medical	1	failure. List only one cause on each line.	Between Onset and Death
xaminer		Immediate Caulle (Final disease or condition resulting in death) Due to (or as a consequence of):	
	<u>,</u>	Sequentially list conditions, b	
	Examiner	E chase Enter Un Jerlying Couse (Disease or injury that initiated	
ited d ansit	Exa	events resulting in death) Last Due to (or as a consequence of): d.	
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(D # E a)	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 4 Julya high	·
Box 6876 death certificate the attending phy ed for use as the	Physician/N	past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (Specify)	Day Year
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rds, I v requires s been sig should be	ted	24a. Was an 24b	. Were autopsy findings available
	Completed	autopsy performed?	prior to completion of cause of death?
tal Rection: The certificate ector, page			1 Yes 2 No
Vita ysiciau his cer directe	o Be	examiner? Hospital: Other, Name Other, Name Other, Name Other, Oth	Other:
		27 Manner of Death 28a Date of Injury 28h Time of Injury 28c Injury at Work? 28d Describe how injury occur	ımed
	atio	The standard of the standard o	
Division pital or Attendi ours after death. teral Director: /	Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Num or Town, State) 28f. Location (Street and Num or Town, State) 1809 North Fulton Avenue	nber or Rural Route Number, City Baltimore, Md
Hospit 24 hour Funer: ely fill		1 /98 (Jenuier	
Division To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the	Medical	(check only one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and and manner stated.	
F 3 F 3	Me		gned (Month, Day, Year)
		0-10-1	er 7, 2012
		30. Name and address of person who completed cause of death (item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
S	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	
Regis			

NATHANTEL 055 AS

Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Nathaniel Glenford Ross DECEMBER 4:41PM 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SINAI HOSPITAL OF BALTIMORE CITY N/A BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 218-46-8998 63 yrs. **Director** 1**X** M 2 □ F 02/09/1949 MD Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director MD N/A Baltimore 1 ¥ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 751 W. Saratoga St. #304 21201 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian er than "natural", or ite the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Specify: Black 3 Widowed 4 XDivorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 9 th College (1-4 or 5+) Janitorial Maintenance State of Maryland Be is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nathaniel Dorsey Martha Ross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gladys Dorsey (Sister) 7211 Valley Country Ct. Pikesville, MD21208 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State On-Site Crematory 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD ²²Joseph H. Brown, Jr. Funeral Home PA 2140 N. Fulton Ave. Baltimore, MD 21217 21. Signature of Fune of Service Licens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 DAYS Immediate Cause (Final Pnysician NON ELEVATION MYOCARDIAL INFARCTION disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ATHEROSCLEROTIC HEART DISEASE YEARS Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Cause (Disease or injury attending physician and I for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death signed by the a Part II. **Other significant conditions** contributing to death but not resulting in the underlyi<mark>n</mark>g cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ TYPE 2 PLABETES MELLITUS 1 MY Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? HEART D'ISEASE: PERIPHERAL 24a. Was an autopsy PISEASE. After this certificate 2 No 1 ☐ Yes 2 ☑ No 1 🗌 Yes • Hospital or Attending Physician: 24 hours after death.
• Funeral Director: After this certificietely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မှ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Matural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier CTODIE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SEMIPLA MBBS GOPIE SINAI HOSPITAL OF BALTIMORE 31. Date filed (Month, Day, State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 6:58 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore University 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year) 9-25-1947 65 Director 213-52-3678 1 🖾 M 2 🗆 F Yrs <u>baltimore</u> 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours efter death with the Maryland Director 1 🗆 Yes 2 🔀 No MD Bel Air Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 803 Winslow Court 21015 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married 1 XYes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White "naturel", 3 Widowed 4 Divorced Year or Dates 27 is marked other then "natural traumetic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Master Electrician Crown Packaging Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ralph Nelson Rook Jeanette Regina DeBardi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 21015 Wife Barbara Rook 803 Winslow Court, Bel Air MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Depertment of H
Important: If ite
eny Injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bayview Crematory 12-15-2012 Dundalk, MD 21. Signature of Funeral Service Licenses Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk MD, 21222 Walls 23a. Part 1. Enter the disease, or complica ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to or as a consequence of) cemio Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events resulting in death) Last Examine Due to (or as a consequence of). physician and s the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Medical Certificate: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death signed by the et id be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø Unknown After this certificete hes been situneral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 X-No 1 🔲 Yes 1 Sunpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

Records, P.O. Box 68760 Division of Vital within 24 hours after death.

To the Funerel Director. After this completely filled in by the funeral of

> State Registrar

29a. Certifier (Check

only one) 29b. Signature and tit

31. Date filed (Month, Day, Year)

X DHMH 17 Rev 06-2011

pe son who completed cause of death (Item 23a) (Type, Print)

32.S

1 Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

200

Baltimore

13

2012

12-09439

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Lloyd St. Rose State of Maryland / Department of Health and Mental Hygiene 2012 40778 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day December 11, 2012 1745 hrs Medical Examiner Lloyd St. Rose c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Dundalk **Baltimore County** 7805 Meath Road If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director 129-34-3464 March 6,1937 Country Panama 1X M 2 F 75 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County Md. Baltimore Dundalk 1 Yes 2X No with the Maryland 10g. Citizen of What Country 10e. Street and Number 10f, Zip Code 7805 Meath Rd. 21222 **USA** 14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc 2 X Married 1 Never Married Black 1 X Yes 2 No specify: If Yes, Give Year Specify: 3 Widowed 4 Divorced <u>≨</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) leted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 Comple permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thai injury or other traumatic event, the Medic. Self Employed Home Remdeling 12 yrs. 2 yrs. 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Solomon James Edward Dlecereta Dacosta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Florence St.Rose wife 7805 Meath Rd. Dundalk Md. 21222 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Itimore. crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Dec. 15 Bayview Crematory Baltimore 2012 4 Donation 5 Other Specify 22. Name and Address of Facility 21. Signature Connelly Funeral Home of Dundalk 7110 Sollers Point Rd. 21222 23a. Part.I. Enter the disease, or c. polications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician een Onset and failu List only one cause on each line /Medical Death Immediate Cause (Final disease a Valvular Heart Disease Ėxaminer or condition resulting in death) Due to (or as a consequence of) b. Aortic Stenosis Sequentially list conditions, Due to (or as a consequence of): if any leading to immediate cause. Enter Underlying Cause Congenital Bicuspid Aortic Valve (Disease or injury that initiated Due to (or as a consequence of) Exar events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 burs after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the fineral director, page 2 should be detached for use as the burial - transit Physician/Medical AMENDED23a-c,27,per me,g936 2-13-13 sm X UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 Other: Scene 1 🗸 Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury Certification: 1 X Natural 1 Yes 2 No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) December 13, 2012 O.C.M.E. 30. Name and address of person who complet ause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Russell Alexander MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year) State Registra

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#8 & 19b Per ANA BD G934 12/26/2012 IH
State of Maryland / Department of Health and Mental Hygiene
Amend 7&19b per SAB G935 1/2/13 dk
Certificate of Death

Reg. No. 2012 For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 23, Physician/ 2012 6:40 AM M November George F. Shinham Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington 10116 Sharpsburg Pike Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 924 Hours 215-26-1718 1**X** M 2 □ F **Director** 72 **72** Maryland Feb 23, 1940 Usual Residence of Decedent 28a-f show 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10d. Inside City Limits "natural", or items 23a or 28a-f sho dical Examiner must be notified at Director 1 Yes 2 No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10116 Sharpsburg Pike 21740 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces?

X Yes 2 \(\sum \) No 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: Specify: white 43-45 3 Widowed 4 Divorced Completedh and Mental Hygien... avent, the Medical E: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) postal system 12 0 mail carrier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. ပ Annie Margaret Fiery Ralph Shinham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18381 21740 Fairview Road Hagerstown, MD David Shinham/son 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 N Donation 5 Other (Specify) . Signature Funeral Sen 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions cause. Enter Underlying Examiner Due to or as a consequence of Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the at d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No SURVEY STREETE YEARS 24a. Was an s certificate has b director, page 2 s autopsy 1311 the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 6372122A 2 No 1 Tyes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural FACILITY 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident after deat Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State LEUN BURN 24 hours a Medical 1 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier соmpletely 2 Hedical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 93 IVW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FULENEY 111 MARTINIBURG VAME 510 BUTLER AVE ARSTE, 31. Date filed (Month, Day, Year, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dencer Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death Examiner :43 imore lindemere tuenue 8. Date of Birth (Month, Day, Year) Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Days Hours Director 1 🗆 M 2 🗗 F 85 Yrs. 9-30-1927 ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, <u>the Medical Examiner must be notified at</u> permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MA more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ール 1 Yes 2 No Specify Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last ၉ tarmon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Husband imore MD 21218 20a. Method of Disposition 20b. Place of Disposition (Name of gemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Juines Mills MD 4 ☐ Donation 5 ☐ Other (Specify) 12-27-2012 Signature of Funeral Service Licenses Greene Funeral Services 22. Name and Address of Facility Vaughn C. 1401553 Kood 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) grow Medical Due to (or as a consequence of) Examiner bilateral Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or se a nonsequence of: attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed vas cul that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
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To the Funeral Director: A
completely filled in by the f Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Why Krd 12-14-2012 D0070832 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 N EUTAW ST # 308 Baltim Dre MD 21201 a3 MMAHOM G 31. Date filed (Month, Day, Year) State rack Registrar

DHMH 17 Rev 06-2011

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Page 1 nent of ant: If i ury or o		1 ☐ Burial 2 ☐ Cremation 3 4 🔀 Donation 5 ☐ Other (Spe	Removal from State	се	metery, cren	natory or other plac	e)							
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2 Medical Exa	hysician: To the best of aminer: On the basis of e	examination	and/or invest	tigation, in my opinio	n, death occ	curred at	the time, date a	nd place	e, and due t	o the cau	se(s) and ma	anner stated
To the vithin To the comple	Σ	only one) 3 L Certifying N 29b. Signature and title of certifier	lurse Practitioner; To th	e best of m	y knowledge,	29c. License		e and pia			e(s) and ma ite signed (
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** SCOH 11 17 2012 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore City Future Care Cold Spring Baltimore, M If Under 1 Year If Under 24 Hrs. Maryland 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min Months Hours 1**∑** M 2□ F Oct 26, 1934 Maryland 218-30-6652 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State a or 28a-f show t be notified at 10b. Count 1 ☐ Yes 2 ☑ No Director Reisterstown Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 6 Brookbury Drive #B1 21136 "natural", or items 23a Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give black 1 ☐ Yes 2X No Specify: 2 3 Widowed 4 Divorced Year or Dates: Completed un the Medical I 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wi.
Department of Health and Mental Hygien
Important: If item 27 Is marked other thi
any injury or other traumatic event, the
once. research analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edith Smith Harry Stanley Scott 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 235 Mary Jane Lane Bel Air, MD 21015 George Scott/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signatur: Funeral ervice Lice s wade 22. Name and Address of Facility State Anatomy Board Baltimore, MD 21201 655 W. Baltimore Street Director 23a. Patt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) End Stuge **Physician** /Medical Due to (or as a conse mence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine Due to (or as a consequence of): Physician/Medical use IF FFMALE: if yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Donknown Diabetes mellitus plnods Completed Pulmondry Disease 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Obstructive 24a. Was an autopsy performed 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one 1 Yes 2 No 2 within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death 1 Natural Certification: 2 Accident

certificate be executed ig physician and as the burial-trar P.O. Box 68760, nding atter for u signed by the a Division or Vital Records, ate has l certificate this

Hospital or Attending

within 24 hours a To the Funeral I

filed within 72 hours after death with the Maryland Hygiene.

Baltimore, Maryland 21215-0036

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☐ Pending investigation	28a. Date of Injury (Month, Day Year	28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
Could not be determined	28e. Place of injury - A building, etc. (Sp.	t home, farm, stree	t, facto	ry, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)

. Certifier	1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
(Check only	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
one)	and manner stated.

29b. Signature and title of certifier Voujah. appleon CRNP 29c. License number R120938 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) Type, Print) Swite 204 Parkville mp 21234

State Registrar 3 ☐ Suicide 4 ☐ Homicide

298

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death lent's Name (First, Middle, Las) Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Essex 821 Cedar Ave. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) Birthplace (State or Foreign) **Funeral** Jan. 24, 1939 Days Hours Min. 213-36-0553 1 □ M 2 H F 73 Director 27 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Me Acal Exeminer must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 ☐ Yes 2 ☐ No Baltimore **Essex** Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21221 821 Cedar Ave. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 XWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Home Housewife 12 yrs. permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygie Important: If tiem 27 is marked other any Injury or other traumatic event. II once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harold William Richards Anna Downey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 210 German Hill Rd. Dundalk Md. 21222 19a. Informant's Name/Relationship (Type, Print) William Swayne 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Dec 1^{Date} 20c. Location - City or Town, State 1 🔁 Burial 2 🗌 Cremation 3 🗌 Removal from State Baltimore bak Lawn Cem. 4 Donation 5 Other (Specify) 2012 21. Signature of Editeral Service 22. Name and Address of Facility Connelly Funeral Home of Dundalk 7110 Sollers Point Rd. 21222 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physic and Liver Disease END-Stage disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA |은 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated nstlagapamemo 00057465 12/14/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bathmore MD NSKAJAPAILSEMP 2835 Smion /N

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 05C 2012 December /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XF Months 67 218-44-4600 May 2,1945 Maryland **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

nt: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10c. City, Town or Location Director MD Baltimore Dundalk 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 7857 Kavanagh Road 21222 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Cafeteria Baltimore County Schools 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Donald Cunningham Connie Mariano 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Henry G. Schroll Sr. Husband 7857 Kavanagh Road, Dundalk, Md. 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ot once. 1 Burial 2X Cremation 3 Removal from State Baltimore, Maryland Bayview Crematory 12, 2012 4 Donation 5 Other (Specify) of Funeral Service Licensee Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shork, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cancer Metastate Breast **Physician** /Medical Due to (or as a consequence of): **Examiner** Box 68760. Physician/Medical or Attending Physician: The law requires that the death certificate be

Division of Vital Records, P.O.

dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect. Due to (or as a consect.) Due to (or as a consect.)	quence of):	espirato	y talu	-		
by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of c	al death 3 Ectopic			23d. Date of delivery Month Da		
	Part II. Other significant conditions o	ontributing to death but not re	sulting in the underlying	g cause given in Part I.		co use contribute to the		
Completed					24a. Was an autopsy performed?	prior to comp death?	y findings available bletion of cause of	
e 0	25. Was case referred to medical	25. Was case referred to medical 26. Place of Death (Check only one)						
To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Impatient 2	ER/Outpatient 3 🗆 🛭	OOA Other: 4 Nursing I	Home 5 Residence	6 ☐ Other (Specify)		
ation:	27. Manner of Death 1 ☐ Alatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? _ 1 ☐ Yes 2 ☐ No	28d. Describe how in	ijury occurred		
Medical Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place of injury - At h building, etc. (Special		ry, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
dical (ysician: To the best of my kno niner: On the basis of examina and manner stated.						
Me	29b. Signature and title of certifier		25	9c. License number	29d. I	Date signed (Month, Da	y, Year)	

35M

10d. Inside City Limits

Approximate Interval Between Onset and Death

December 11, 2012

4940 Eastern Avenue, Baltimore, MD, 21224

1 Yes 2X No

State Registrar

30. Name and address of pe

son who completed cause of death (Item 23a) (Type, Print)

within 24 hou To the Fune completely fi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #7&8 Per INF G934 12/21/2012 JH State of Maryland / Department of Health and Mental Hygiene 2012 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 17, 2012 Physician/ 7:45 PM M Edward F. Tilling Jr Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 39 Deep Channel Drive Berlin Worcester Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign 6. Sex **Funeral** Country)
Maryland Days (Month, Day, Ya 218-28-5606 Director 1 **X** M 2 \square F May 8, 90 79 Yrs Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Berlin Worcester MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral USA 21811 39 Deep Channel Drive death \ 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No within 72 hours after Specify: White Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) engineer telephone compnay 12 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mary CAtherine Maule permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. Edward Francis Tilling Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 39 Deep Channel Drive Berlin, MD Bernadette Tilling/spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ▼ Donation 5 Other (Specify) Signature of Funeral Service Licens 6 State Anatomy Board 655 W. Baltimore Street Director Baltimore, ΜĎ 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one of the in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ENEBROVASCUL CLIDENS disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examir by the attending physician and stached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death detached 9 Unknown 9 Unknown Hospital or Attending Physician: The law requires that the C 24 hours after death.
Funeral Director: After this certificate has been sinned by the the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed d be de by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed plnous 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eral ulrector. After this certificate has filled in by the funeral director, page 2 s autopsy 1 Yes 2 No 2 N Yes 25. Was case referred to medical To Be 26. Place of Death (Check only one) Hospital Other: 1 \(\text{Yes} 2 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) 5 Pending 1 Natural 1 Tes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hou To the Funer completely fi Certifying Nurse Fractitioner: to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated of certifier 1246257 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CAUCH CASTANDAM) (BZY OD OCOM CITY BIVO GEXCIN, WOZIEV) 31. Date filed (Month, Day, Year) park Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-09363 State of Maryland / Department of Health and Mental Hygiene Elijah Thomas, Jr. 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day December 8, 2012 2010 hrs Medical Examiner **ELIJAH** THOMAS JR. 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Parkville **Baltimore County** 3 Mercury Court If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** oreign MARYLAND Davs Hours Director 05/12/1951 1 X M 2 F 61 212-56-9106 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location iny 10b County 1 Yes 2 X No or items 23a or 28a-f show must be notified at once, MARYLAND BALTIMORE CO BALTIMORE death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21234 3 MERCURY CT. Funeral 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married 1 Yes 2 X No specify. 3 Widowed Yes, Give Yee Specify: BLACK 4 Divorced permit Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner. 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 MAINTENCE CUSTODIAN 12yrs 2yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ELIJAH THOMAS SR. CARRIE HARRELL THOMAS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2104 E. Kennicott Rd., Baltimore, Md., 21244 Georgetta Thomas/Wife 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date crematory or other place) 1 XXBurial 2 Cremation 3 Removal from State 12-18-12 OWINGS MILLS, MARYLAND GARRISON FOREST 4 Donation 5 Other Specify: 22. Name and Address of Facility Signature of Funeral Service Licenses WILLIAM C. BROWN COMM. FUNERAL HOME P.A. 1206 W NORTH AVENUE Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only on Medical aHypertensive Atherosclerotic Cardiovascular Disease Death Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate he executed Physician/Medical AMENDED 23a, 27, per me, g934 12-19-12 sm X UNPENDED signed by the attending physician I be detached for use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown gΓ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ś 1 Yes 2 No 3 Probably 4 V Unknown Completed After this certificate has been r funeral director, page 2 should 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? death? ✓ Yes 2 No ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Inpatient 2 Other₄ Nursing Home 5 Residence 6 🗹 Other: Scene ER/Outpatient 3 DOA 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 1 X Natural 1 Yes 2 No

cation: Pending To the Funeral Director: completely filled in by the Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide 4 Homicide determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 9, 2012 30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Ling Li, MD

State Registrar

31. Date filed (Month, Day, Year) Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 20 | 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 12:15 am Sybil P. Yermack 2012 December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Potomac Montgomery Manor Care Potomac 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Days 057-03-9186 Director 1 🗆 M 2 🗴 F 96 09/11/1916 New York Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Potomac Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? by Funeral within 72 hours after death with u.s.A. 20854 10714 Potomac Tennis Lane 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Retail Manufacturing Textile Designer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Estelle Hutter William Popper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a 107 Piping Rock Dr., Silver Spring, Maryland 20905 <u> Joan Schwarz - Daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it any injury or o 1 X Burial 2 Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/16/2012 Maspeth, New York Zion Cemetery 21. Signature of Funeral Service Licens 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Congestive Heart Failure disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner <u> Aortic Stenosis</u> Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events attending physician and for use as the burlal-transit Exami The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Dav signed by the a d be detached f 9 Unknown P.0. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No r this certificate has eral director, page 2 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: T within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Be Other: 4 [X] Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 💢 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Poertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and the of certifie 12/2012 D35579

Registrar

DHMH 17 Rev 06-2011

State

Susan Miller, M.D., 8218 Wisconsin Avenue, Bethesda, Maryland 20814

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

DEC 1 7 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 6 Physician/ 6:50 PM Month December Edward Davis Vidali 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Joseph Medical Towsor Center If Under 1 Year If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Director 217-24-6301 1 X M 2 □ F 85 July 29, 1927 Maryland Usual Residence of Deceden Department of Heelth and Mentel Hygiene. Importent: If item 27 is merked other then "neturel", or items 23e or 28e-f show eny Injury or other treumetic event, the Medical Examinar must be notified at filed within 72 hours after death with the Maryland of Hygiene. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore Towson 1 Tes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 500 Virginia Avenue #902 21286 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: white Specify: Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ attorney 1aw Be aryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed end Mentel H ည Peter Vidali t. Page 1 end 2 should be tment of Heelth end Men rtent: If item 27 Is merke Anna Guarino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Σ Danielle Vidali/daughter 18838 Riverwood Drive Bend, OR Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) Sign ture of Funeral Sav Director 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ulmonar ema Medical resulting in death) Due to (or as a consequence of): Examiner rdiogen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). ettending physicien end for use es the burlel-trensit the Hospital or Attending Physicien: The law requires that the deeth certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year 4 Pregnant at time of death 1 Yes 2 9 Unknown 2 No After this certificete has been signed by the of tunerel director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ ardiomyopa Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) <u>မ</u>ူ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No Director: A 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours of To the Funerel D completely filled in Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: Or the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D46356 December 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 Osler Drive Towson Maryland 21204 Tabassi W.D. Knosrow

State

Registrar

31. Date filed (Month, Day, Year)

17

2012

SAR

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dec. 14 Day Physician/ 20**12** 1:50 PM S. Vavrina Gertrude Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Parkville Oak Crest Care center 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 91 215-14-6737 Director 1 □ M 2 1 F 1921 Maryland 5 Vrs Feb. Usual Residence of Decedent or then "naturel", or items 23a or 28e-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 X No Parkville Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21234 8832 Walther Blvd 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. ≥ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. Specify: White Completed 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) marked other then Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any Injury or other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္ဝ Barbara A. Detzer V. Smearman Joseph 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print, 120 Fallen Spruce Drive, Asheville, NC. 28806 Son Vavrina Vernon J. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State cometery, crematory or other place)
Lake View Mem. Park 12/18/2012 1 🕅 Burial 2 ☐ Cremation 3 ☐ Removal from State Sykesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral 22. Name and Address of Facility Ruck Towson Funeral Home 1050 York Road, Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury Due to (or as a consequence of) signed by the attending physician and Id be detached for use as the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? Month Dav 5 Other (specify) Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24 hours efter death. • Funeral Director: After this certificate has been signed in by the funeral director, page 2 should to the funeral director, page 2 should to the funeral director. 24b. Were autopsy findings available prior to completion of cause of death? DIAbeTES 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 8 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24 hound to the second 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) who completed cause of death (Item 23a) (Type, Print) Walther Blud State Registrar

DHMH 17 Rev 06-2011

19/14/12

GERTRUD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 2358 Eleanor Phelps Wilson December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Howard Examiner Columbia Gilchrist Hospice Birthplace (State or Foreign Country)
 MT 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days (Month, Day, Year) March 8 1927 85 193-20**-**7274 1 □ M 2 🗗 F Director MD Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mentel Hygiene.
If them 27 is merked other then "natural", or Items 23e or 28a-f show often then the the medic event, if a Medical Expriser must be notified in 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Eldersburg Carroll MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21784 2013 - 3D Rudy Serra Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. Š 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify: Specify: white Completed 3 XWidowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

| Compared to the property of the 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Johns Hopkins APL bookkeeper 12 Be permit. Pege 1 and 2 should be filed Depertment of Health and Mentel Hy Important: if them 27 is merked oth any lipiny or other treumetic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
Louise Linthicum ည Olan P. Phelps Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6901 Rawhide Ridge, Columbia, MD 21046 Mrs. Susan Econ (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 12-17-12 Clarksville, MD 4 Donation 5 Other (Specify) St. Louis Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel > Yough Jarghy Sterbart Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician/ CEREBROVASCULAR INFARCTION Medical Examiner ATRIAL FIBRILLATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): ettending physician and for use es the burlal-transit The law requires that the deeth certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 Å No 9 ☐ Unknown Month Day cate has been signed by the page 2 should be deteched 9 Unknown P.0. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 🗆 No 1 🗌 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ဂ္ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 💆 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural Accider 5 Pending Division 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier

State Registrar

29b. Signature and title of certi

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CEDAR

RO MD

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Physician/ atherine VVells December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Baltimore Emerald Estates 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Director 395-09-7058 1 □ M 2 🕅 F Yrs August 28. 1918 Wisconsin Usual Residence of Dece is than "natural", or items 23e or 28e-f show the Medicel Examiner must be notified at 10b. Coun filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 A Yes 2 No Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral U.S.A. 6111 Baywood Avenue 21209 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Yes Give Specify: White 3 12 Widowed 4 Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If them 27 is marked other than "n any Injury or other trainment. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Elaine Bell Henry Sanborn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Wells (son) 6111 Baywood Avenue, Baltimore, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State Dec. 19, 2012 4 Donation 5 Other (Specify) Wisconsin Memorial Park Brookfield, Wisconsin 21. Signature of Funeral Service Line see 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland 21211 23a. Part 1. Enter the disease or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) mentio years Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause [Disease or Injury Examine Due to (or as a consequence of): 24 hours after death.

2 hours after death.

9 Funeral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4. Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Tyes Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie D0051552 npleted cause of death (Item 23a) (Type, Print) 838 Greene

Registrar DHMH 17 Rev 06-2011

State

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31. Date filed (Month Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 13 December 2012 6:35 PM Hugh K. Warren, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Lorien Nursing & Rehab Elkridge If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Months Director 195 28 0398 1 X M 2 - F 01/02/1935 Virginia 77 Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location at the Maryland **Funeral Director** notified 28a-f 1 Yes 2 No Columbia MD Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe ò must be permit. Page 1 and 2 should be filed within 72 hours after death with 23a United States 21044 4921 Good Hours Place ral", or items a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian 11. Marital Status Black, White, etc. or i þ 1 🕱 Yes 2 □ No
If Yes, Give
Year or Dates. 1958-64 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 'natural", Completed 3 Widowed 4 Divorced er than "natur the Medical E 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) <u>Procurement Specialist</u> NASA 4 Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, It once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Margaret Baker Hugh K. Warren, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4921 Good Hours Place Columbia, MD 21044 Susan Warren/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Cremation Cntr of MD | 12-14-2012 | Hanover, MD 4 Denation 5 Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signatur of Funeral Service Manuta nonco MD 21043 4112 Old Columbia Pike Ellicott City, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ state Ca disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner Due to (or as a consequence or). if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death ed by the at detached for 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy 1 ☐ Yes 2 🕱 N certificate 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify, 1 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred after death. Director: After Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) الم 24 hou. الله **Funeral Dir.** الا filled in bv 4 Homicide determined Medical 1 😿 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nuyse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the F

complet 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 82 Dec. 14, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOX 1525 Will S MO 21117 Wolokolie 31. Date filed (Month, Day, 32. Registrar's Signatur State

Registrar

40793 State of Maryland / Department of Health and Mental Hygiene 0 | 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 11:07 AM <u>December</u> Cheryl Williams Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Joseph Richey Hospice Baltimore If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Hours Country) Director 212-70-7257 1 🗆 M 2 🖾 F 54 Oct 21, 1958 Maryland 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 🗌 No MD Baltikore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4001 Penhurst Avenue 21215 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces Black, White, etc. Yes 2 No \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: black. If Yes, Give 3 Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) ith and Mental Hyglen 27 is marked other ti r traumetic event, th 10 0 cook food industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Page 1 and 2 should be f Charles Williams Brinzella Lesley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Katherine Lesley/sister 4001 Penhurst Avenue Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☒ Other (Specify) in state 21. Signature Rona III. 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part 1\ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
MMTN > Immediate Cause (Final Physician Dancreate disease or condition Medical resulting in death) to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events and initiated events are listed in the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions, in the conditions, if any leading the conditions, if any leading the conditions, if any, leading the conditions, if any, leading to immediate cause of the conditions of the Examine Due to (or as a consequence of): sician and burlal-transit Due to (or as a consequence of) resulting in death) Last erei Director: After this certificate has been signed by the ettending physician filled in by the funeral director, page 2 should be deteched for use as the buris Physician/Medical certificate be IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery The lew requires that the deeth in the past 12 months? Month Day Year ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1) labetes Type 2, Records, 1 Yes 2 No 3 Probably 4 Unknown Naviotics recovery - methadune 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ★ o 24a, Was an autopsy performe to bacco use diarrhea anyiete 2 **X**10 Hospital or Attending Physicien: 25. Was case referred to medical examiner?

1 Yes 2 Vio Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Nosphe ၉ 1 Inpatient 2 ER/Outpatient 3 DOA of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending Division 1 Yes 2 No 24 hours after death. Funerel Director: A 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical within 24 hour To the Funer completely file 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one the 29c. License number 29d. Date signed (Month, Day, Year) acolmald ins s of person who completed cause of death (Item 23a) (Type, Print) Blud 4724 Campbell Suite 200, Balt. (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hydriana

			For State	State of M	aryland /	Department of Certificate of		l Mental Hy	giene _{Reg. No} 2012	40794
	_		Registrar 1. Decedent's Name (First, Midd	e, Last		Certificate of	Death	2. Date of Dea		3. Time of Death
	Physicia Medic		rear	William	N>			Month (-2	Day Year 201	Z 0130 M
,	Examin	ier	4a. Facility Name (if not institution to the control of the contro	n, give street and number)	0000	4b. City, Town,	or Location of Dea	ath	4c. County of Dea	/
	Funeral		5. Social Security Number		e (In yrs. last bir	thday) If Under 1 Yea Months Day			h 9. Bi	rthplace (State or Foreign
	Director		infant Usual Residence of Decedent	1 □ M 2.72 F		Yrs.	3.			yland
	f ehow	tor	10a. State 10b. Count	,	10c. City, Tow	n or Location				10d. Inside City Limits
	r 28e-	Director	MD Howa	rd	Co	olubmia 10f. Zip Code			10g. Citizen of What C	1 Yes 2 No
	s 23e c	Funeral	10208 Hickory	Ridge Road	<i>‡</i> 303		21044		USA	outiny?
	death r items		11. Marital Status	12. Was Decedent I Armed Forces?		13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whit	
036	s after rel", o	ed by	1 X Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	If Von Cine	No	1 ☐ Yes 2 💢 🖡	lo Specify:			lti racial
5-0	"2 hour	Completed		ent's Education est grade completed)	16a	a. Decedent's Usual Occ (Give kind of work don	e during most of we	orking	16b. Kind of Business	:/Industry
212	vithin 7 giene. er then		Elementary/Secondary (0-12)	College (1-4 or 5	5+)	iife. DO NOT use retire infant	d)		infant	
pu	ital Hyged other	To Be	17. Father's Name (First, Middle,	,	•		1	ame (First, Middle,	,	
ıryla	ould by Mer marketic		David Willi 19a. Informant's Name/Relation		100	h Mailing Addraga (Ctro	1	Rebecca		- C- d-1
N.	id 2 sh salth ar n 27 ie er treu		Howard County	, , , , ,	- 1	b. Mailing Address <i>(Stre</i> e 5755 Cedar				ip Code)
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23e or 28e-f show wayl figury or other treumetic event, the Medical Example must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☒ Other		cemete	of Disposition (Name of ery, crematory or other p	ace)	Date	20c. Location - City of	r Town, State
Balti	permit. F Departm Importe eny Inju		21. Signature of Funeral cruice					l ard 655 W .201	. Baltimore	Street
14			23a. Part 1. Enter the disease, of shock, or heart failure. List	r complications that caused	d the death. Do	I Baltimor not enter the mode of dy			rest,	Approximate Interval Between
	nysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	- extre	me	promatu	why		1)	Onset and Death
المسا	Examiner		resulting in deathy	Due to (or as	a consequence	h f):	7			
	n #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequence	of):				
	ecuted end el-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence	of):		-		
09/	icate be executed physiclen end is the buriel-transit	edical		d						
	artificat ding ph	/Mec	IF FEMALE:	23c. If yes, outcome	of programmy					
Box 68	To the Hospital or Attending Physicien: The law recuires that the death certific within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettending completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		2 Fetal deat	th 3 Ectopic pregna 5 Other (specify)	ncy		23d. Date of de Month	elivery Day Year
P.0	s that th gned by be detac	by Ph	Part II. Other significant condit	ons contributing to death b	out not resulting	in the underlying cause	given in Part I.	23e. Did to	obacco use contribute to	o the cause of death?
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Division of Vital Records, P.O.	The law ate has pege 2 s	Completed						24a. Was autop autop perfo 1 \square Yes	prior to death?	topsy findings available completion of cause of s
/ital	slcien: certific irector,	Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☑ No	Hospital:		10	Place of Death (Ch			
of <	ng Phy ter this nerel d	te: To	27. Manner of Death	28a. Date of inju	ry 28b.	Time of 28c. Inj	4 ∐ Nursing ury at		lence 6 Other (Spec	cify)
ion	ttendir death. tor: Afi the fu	Certificate:	1 ☑ Natural 5 ☐ Pend 2 ☐ Accident Invest 3 ☐ Suicide 6 ☐ Could	gation not be		M 1	ork? ☐ Yes 2 ☐ No			
Divis	ital or Atten irs after dea el Director lled in by the		4 ☐ Homicide deteri		ury - At home, fa c. (Specify)	arm, street, factory, office)	28f. Location (S City or Tow	treet and Number or Ru n, State)	ıral Route Number,
	To the Hospital or Attending Physicien: The law within 24 burus after death. To the Funerel Director: After this certificate has completely filled in by the funerel director, page 2	Medical	(Check 2 ☐ Medical	Physician: To the best of Examiner: On the basis of e Nurse Practitioner: To the	xamination and/	or investigation, in my opi	nion, death occurred	d at the time date a	nd place and due to the	cause(s) and manner stated
	To t		29b. Signature and title of certific	5 ()		29c. Licer	nse number	./3	29d. Date signed (Mont	h, Day, Year)
			30. Name and address of person	who completed cause of d	eath (Item 23a)	(Type, Print)	1,5400	14	17/01/	2019
	Stat		Christike (31. Date filed (Month, Day, Year)	Richards	. 7	025 Map	Maur	Blvd	Fulton	MD 20759
	Registra		DEC 17	2012 Serva	p. 4	park				

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			For State	te of Maryland / Depa			ntal Hygier	2012	40795	
			Registrar 1. Decedent's Name (First, Middle, Last)	Cer	tificate of Dea		Reg.	Reg. No.		
	Physicia Medi		Lorraine L. Wontrop			!		Day Year 30. 2012	3. Time of Death	
~	Exami		4a. Facility Name (if not institution, give street and		4b. City, Town, or Loca			4c. County of Dea		
			Jacobs Well Asst Livi 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Bel Air	Inder 24 Hrs. 8		Harfor	~	
	Funeral Director		218-22-6492 1 D M 2	TE Van	Months Days Ho		Date of Birth Month, Day, Yea		thplace (State or Foreign untry)	
	d tow	L	Usual Residence of Decedent 10a. State 10b. County	85	<u></u>	Au	g 5, 19	27 Mar	yland	
	larylar ka-fst ified a	Director	MD Harford	10c. City, Town or Loc					10d. Inside City Limits 1 ☐ Yes 2 🏋 No	
	the M a or 28	ä	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Co		
	h with ns 23a nust k	Funeral	522 Thomas Run Road		210	15		USA		
"	or iten	y Fu	Arme	Decedent Ever in U.S. ed Forces? If Yes 2 X No	Vas Decedent of Hispanio Yes, specify Cuban, Me	ic Origin? (Specify) exican, Puerto Ricar	res or No- n, etc.)	14. Race - Ame Black, White		
036	ırs afte ıral", (I Exan	Completed by	2 17 Widowad 4 Diversed If Yes		☐ Yes 2 🌠 No Spe	ecify:		Specify: wh	ite	
15-0	72 hou "natu edica	plet	15. Decedent's Education (Specify only highest grade compi	eted) (Give k	ent's Usual Occupation and of work done during	most of working	16b.	Kind of Business	Industry	
72	/ithin 7 iene. r than the M	Con	Elementary/Secondary (0-12) Colle	ge (1-4 or 5+) life. DC	NOT use retired)	3		cosmoto]	OGA	
pu	filed val Hyg	Be	17. Father's Name (First, Middle, Last)			Mother's Name (Firs	at, Middle, Maide		-087	
ylai	uld be Ment narked natic e	욘	James Francies Pazde	ra	L	Lillian L	ena Poll	nammer		
, Mai	nd 2 shou salth and n 27 is n er traum		19a. Informant's Name/Relationship (Type, Print) Thomas Wontrop/son	19b. Mailin 1419	g Address (Street and Nu C Sharon Ac	umber or Rural Rou cres Road	te Number, City Forest	or Town, State, Zip H ill, MI	21050	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal 4 ☒ Donation 5 ☐ Other (Specify)	from State 20b. Place of Dispos cemetery, crem	sition (Name of atory or other place)	Date	20c.	Location - City or	Town, State	
3alti	permit. I Departri Importa any inju		X 1 11/	Director St	Atte and Address of 5	aciBoard 6.	55 W. Ba	altimore	Street	
_	907 # 9		Mann / W	Ba	ltimore, MD	21201		-		
	Physician/		23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause of Immediate Cause (Final	nat caused the death. Do not enter on each line.	1 -				Approximate Interval Between Opeet and Death	
al al al	Medical		disease or condition	e to (or as a consequence of):	ers Di	sease			5 years	
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09	icate be executed physician and is the burial-transit	edical	d							
687	ertifical ding ph	/Mec	IF FEMALE:							
Box (The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi	Physician/M	in the past 12 months?	, outcome of pregnancy Live Birth 2 Fetal death 3 Pregnant at time of death 5	Ectopic pregnancy Other (specify)			23d. Date of deli	very Day Year	
O. B	the de by the ached	hysi	9 Unknown	Unknown	Other (speedily)		_			
Э.	s that gned I be del	by	Part II. Other significant conditions contributing	to death but not resulting in the un	derlying cause given in F	Part I.	23e. Did tobacco	use contribute to	the cause of death?	
rds	equire	Completed	Viaberes 10pe	*			1 Tes	2 No 3 □ Pr	obably 4 🗌 Unknown	
Records,	e law i e has t ge 2 s	du	Hypertension				24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of	
<u> </u>	sician: The law is certificate has the law irrector, page 2 s	Be Co	25. Was case referred to medical		26 Place of	Death (Check only	performed?	Vo. 1 ☐ Yes	2 No	
Ž	hysicii lis cer l direc	To B	examiner? 1 Yes 2 No Hospital:	I ☐ Inpatient 2 ☐ ER/Outpatient	Othor	Nursing Home 5		6 ☐ Other (Speci	fv)	
o c	ling Pt		27. Manner of Death 1 Natural 5 Pending 28a. D	Pate of injury 28b. Time of Month, Day, Year) injury	28c. Injury at work?		escribe how inju		//	
SIO	Atteno death ctor: /	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	lace of Injury - At home, farm, stree	M 1 Yes 2			nd Number or Rura		
Division of Vital	tal or / s after al Dire ed in t		4 Homicide determined b	uilding, etc. (Specify)	st, lactory, office	201. C	ity or Town, Stat	e)	in Houte Number,	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check 2 L. Medical Examiner: On the	he best of my knowledge, death oc basis of examination and/or investig	ration in my opinion deat	th occurred at the tir	ne date and place	e and due to the o	gueele) and manner stated	
	No the vithin To the comple		only one) 3 U Certifying Nurse Practition 29b. Signature and title of certifier	oner: To the best of my knowledge, c	death occurred at the time 29c. License numb	e, date and place, an	d due to the caus	se(s) and manner as ate signed (Month,	stated.	
			Jande-Rill	els 2 M	D39	1208	254. 0	12/6	12012	
			A	cause of death (Item 23a) (Type, Pri				100		
	- Clark		31. Date filed (Month, Day, Year)	718 NORFISVILLE 2. Registrar's Synature	ED JEC, V	MERETTSU	ILE, 1	W 210	54	
	Stat Registra	~	DEC 1 7 2012 Devi	www. A. Hallingark						

			1- Registrar Certificate of Death Reg. No.) כ
	Physici /Medi		Decedent's Name (First, Middle, Last) Darilyn Watson 2. Date of Death Month Day Year 5/5 A	ath . M
	Examir Funeral Director		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County o	tt oreig
	/land		Usual Residence of Decedent 10a. State	imits
	e Mary Ba-f sh	ctor	MD Baltimore 1½ Yes 2] No
	ath with th	ral Dire	10e. Street and Number 1811 Wilhelm Street 10f. Zip Code 10g. Citizen of What Country? USA	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hjury or other traumatic event, I'm Modral Evaninar must be rediffied at once.	Completed by Funeral Director	(Specify only rightest grade completed) (Give kind of work done during most of working	un
121	within iene. than "	dmo	Elementary/Secondary (0-12) College (1-4or 5+) 9 College (1-4or 5+)	
	e filed and Hyginal Author	BeC	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	
Maryland	should be fi and Mental H s marked ot umatic ever	2	Clarence Watson Marceline Sparrow 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
Baltimore, Ma	Pages 1 and 2 sho nent of Health and 1 int: If item 27 Is ms iry or other traums		Marceline Sparrow/mother 20a. Method of Disposition □ Burial 2 □ Cremation 3 □ Rempval from State 4 □ Donation 5 ②Other (Specify) In State	
Balti	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licensee Ronald S. Wade, Wirector State Anatomy Board 655 W. Baltimore Street	
	Physician /Medical Examiner	er	Baltimore MD 21201 23a. Part 1. Anter the disease, in complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Betwee Onset and Deat disease or condition resulting in death) Approximate Interval Betwee Onset and Deat Death Interval Betwee Onset and Death Interval Betwee Onse	en th
68760,	rtificate be executed ng physician and as the burlal-transit	edical Examiner	Sequentially list conditions, is any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Respiratory foilure Due to (or as a consequence of): Respiratory foilure	
P.O. Box 6	the death certifi y the attending iched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	r
ds, P	uires that the de n signed by the a Id be detached f		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death 1 Yes 2 No 3 Probably 4 Unk	
I Reco	: The faw requir cate has been s page 2 should I	Completed by	Receivent pneumonias 24a. Was an autopsy findings ava prior to completion of cause death? 1 Yes 2 No	ilabl e of
Vita	ysician: The lis certificate hidirector, page	Be	25. Was case referred to medical examiner? 116/Ves 2 No	
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use.	Certification: To	1	,
	ne Hospit. 24 hours ne Funera	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	To the within 2 To the complete	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
			* DESAI MD >16 Mai elen Choice Balhmone MD 21218 31. Date filed (Month, Day, Year) 32. Registrar's Ingnatural 1	_
	Sta Registr		31. Date filed (Month, Day, Year) DEC 1 7 2012 A 32. Registrar's agnature B 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford Aberdeen 117 Edmunds Street Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours Min. Director 213-78-2521 1X M 2 □ F 53 June 5, 1959 Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Harford Aberdeen 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20 Lewis Drive 21001 USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14 Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 🎇 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education unk 16b. Kind of Business/Industry (Specify only highest grade completed) construction Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Clay Clinton Wagoner Evelyn Billings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debbie Simons/sister 117 Edmunds Street Aberdeen, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 N Donation 5 C Other (Specify) nature of Funeral Ser 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 23a. Palt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Liver Disease Immediate Cause (Final End-Stage Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and shed for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for it in the past 12 months? Day Year Pregnant at time of death Yes 2 No g Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 Yes 1 Yes 2 No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2-1 No Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident M Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

MS/Up upn 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1203 NSKajapaksemb 2835 Sm 122 AV

DHMH 17 Rev 06-2011

Registrar

State

31. Date filed (Month, Day, Year)

2012

32. Registrar's Signature

Please	Type or Print in	Black Ir	ndelible Ink. Ensure	All Copies Ar	e Legible.	
For	State of Marylan		artment of Health and	Mental Hygien	ie	
State Registrar		Cer	tificate of Death	Reg. N	10.2012	40798
1. Decedent's Name (First, Middle, Last)				Date of Death Month E	Day Year	3. Time of Death
HERBERT WALK				Month DECEMBER		03:40 AM
4a. Facility Name (If not institution, give s			4b. City, Town, or Location of Deat	h 4	Ic. County of Death	
Johns Hopkins Bayviev 5. Social Security Number 6. Sex			Baltimore If Under 1 Year If Under 24 Hrs	8. Date of Birth	9 Birthi	place (State or Foreign
	M 2□F 73	Yrs.	Months Days Hours Min.		939 V	rginia
10a. State 10b. County	10c. Cit	y, Town or Lo	cation			10d. Inside City Limits
Md. NA		Ba	etimore			1 No 2 □ No
10e. Street and Number Rutla	nd Ave	,	10f. Zip-Code 2/202	10g. C	Citizen of What Cour	ntry?
11. Marital Status 1 □ Never Married 2 ☑ Married	12. Was Decedent Ever in U.s Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		Was Decedent of Hispanic Origin? (S If Yes, specify Cubar, Mexican, Puer 1 ☐ Yes 2 ☐ No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White,	
3 Widowed 4 Divorced	Year or Dates:				Specify: D	ucic
15. Decedent's Edu (Specify only highest grade		(Give	dent's Usual Occupation kind of work done during most of wo	orking 16b.	Kind of Business/Ir	
Elementary/Secondary (0-12)	College (1-4 or 5+)	1	DO NOT use retired) Chine Super Vi			Sugar
17. Father's Name (First, Middle, Last) R Chard	Warke	~		ame (First, Middle, Maid Levine	Wal	Rer
19a. Informant's Name/Relationship (Typ			ng Address (Street and Number or F	2	y or Town, State, Zip	Code)
Wanda Walk	er - WIFE	180	3 Rutland +	re. Bai	70. md.	21202
20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	emoval from State	emetery, cre	osition (Name of matory or other place) Mem. Pl. 12	0	Location - City or To	own, State DWn , M力・
21. Signature of Funeral Service License	5	2:	2. Name and Address of Facility	3405 WIF	ankles	i Lite
Muly m. Ch	uldee		Janus m. Wa	Mace F.S.	Baeto.	md. 21239
23a. Part 1. Enter the disease, or complished in the short of the short failure. List only one	cations that caused the death e cause on each line.	n. Do not en	ter the mode of ying, such as cardia	ac or respiratory arrest,		Approximate Interval Between
Immediate Cause (Final disease or condition	STROKE					Onset and Death
resulting in death)	Due to (or as a conseq	uence of):				
Sequentially list conditions,).					
if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uence of):				
that initiated events resulting in death) Last	Due to (or as a conseq	uence of):				
	·					
	l					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	il death 3	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of deliv Month	very Day Year
Part II. Other significant conditions con	ntributing to death but not res	sulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
				1 🗌 Yes	2 No 3 Pro	bably 4 🗌 Unknown
				24a. Was an autopsy performed:	? death?	opsy findings available ompletion of cause of
25. Was case referred to medical			ge Dines of De	ath (Check only one)	No 1 Xes	2 No
evaminer?	Hospital:	ER/Outpaties		Home 5 Residence	6 ☐ Other (Speci	fy)

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran Division of Vital Records, P.O. Box 68760,

Medical Certification; To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

		TIMES 2 INO TIMES 2 INO	
25. Was case referred to medical		26. Place of Death (Check only one)	
examiner? 1 ☐ Yes 2 XNo	Hospital: 1 Inpatient 2 - ER/Outpatient 3 - DOA	Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify)	
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury	Injury at Work? 28d. Describe how injury occurred 1 Yes 2 No	
3 ☐ Suicide 6 ☐ Could not be determined		100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to 100 to	
29a. Certifier 1 Certifying Ph	nysician: To the best of my knowledge, death occurred at the	the time, date and place, and due to the cause(s) and manner as stated.	

ORIGINAL

RESODO

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEONG, MD

4940 Eastern Avenue, Baltimore, MD, 21224

DECEMBER 13,2012

State Registrar

MADELINE 31. Date filed (Month, Day, Year 2012

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 December Sarah Beale Weaver Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Baltimore Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours (Month, Day, Year) Director 216-20-5179 1 □ M 2 🕅 F 89 Usual Residence of Deceder Nov. West Virginia or than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at filed within 72 hours after death with the Maryland al Hygiene. al Hygiene. d other than "natural", or Items 23a or 28a-1 shov 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 21286 U.S.A. 800 A Southerly Road, Apt 535 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify: f Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16b. Kind of Business/Industry Baltimore City & 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) County Schools School Teacher Be Maryland permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If Item 27 is marked oth ery lipity or other traumatic event 2016. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Wellener William Nelson Beale Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 811 Kingston Road Baltimore, Maryland William K. Weaver IV Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State Hilltop Service Corp. 12-17-2012 Towson Maryland 4 Donation 5 Other (Specify) 21. Signature of Furreral Service Lice 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ omphications disease or condition Medical Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physiclen end for use es the burlel-trensit or Attending Physician: The lew requires that the death certificete be executed (QQ) Due to (or as a consequence of): Physician/Medical P.O. Box 68760 yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Copic pregna in the past 12 months? Day Month Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6-12 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 1 No Fall 2/1/12 Known Investigation s after death 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <u>ک</u> 4 Homicide 800 Southerly Rd. Apt 53 filled in To the Hospital o within 24 hours af To the Funeral Di Edenwald Maryland Medical 1 _____ ing Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ___ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

29b. Signature and title of certifier

aura

31. Date filed (Month. Www.Year

30. Name and address of person who completed cause of deam (Item 23a) (Type, Print)

701

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Charles

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ :30A M 2012 Medical 4a. Facility Name (if not institution, give street and number) or Location of Death 4c. County of Death **Examiner** Ridge Carro DPPER Kesvi curity Number If Under 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 24 Hrs. **Funeral** 117-09-0770 Director 1 M 2 XF 08/29/1919 N.Y. 93 show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Carrol1 Sykesville Md. 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21784 USA 5796 Victor Drive 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 10yrs. Housewife Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Angela Gerace Anthony Condello 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5796 Victor Drive Sykesville, Md. 21784. William T. Zekoll (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 12/18/2012 Moreland Park Parkville, Md. Signature of Fund Service Licenses Haight Funeral Home & Chape 22. Name and Address of Facility P.O. Box 195 Sykesville, Md. 21784. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ End disease or condition resulting in death) years Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Year Month Day 5 Other (specify) Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy certificate 2 No Yes 2 No 1 Yes 24 hours after death.

Funeral Director: After this certific etely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 🗌 Yes 2. No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Sursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) 34849 2012 December 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd & Idersburg MD $\gamma \setminus$ illiam 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. SAN To the Funeral Director. After this certificate has been sinned by the attending physician and	completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A	completely filled in by the

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		Registrar	10-1-11- 1 00	41			Cei	tificate	e of D	eath			Reg. No	012		4080)
Physiciar Medica	al .	1. Decedent's Name (First, I		Bash		G.	Ahı	madi				2. Date of Dea Month Novembe	Day	^{Yea} 20:	12	3. Time of Deat 8:55	
Examine	er	4a. Facility Name (if not insti 246 Perrywi			nber)			4b. City,		Location o ither		g		ounty of De lontge		ry	
Funeral Director	- 1	5. Social Security Number 212-11-1040	6. Se	x □ M 2 💢 F	7. Age	(In yrs. la 89	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day)	(Year)		Birthpla Cou <i>ntr</i> y	ace (State or For y) Tran	
and show	ō	Usual Residence of Deced	ounty			10c. City	, Town or Lo			1		12/17/	1722		100	d. Inside City Lir	
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d 2 shou alth and 1 27 is m er traum		19a. Informant's Name/Rela	ationship (Ty Modjar			Son		-				<i>l R</i> oute Number, Gaithers			,		
Page 1 an nent of He ant: If iter ıry or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Crem 4 ☐ Donation 5 ☐ O	ation 3 🗆	Removal from	n State	CE	lace of Dispo emetery, cren	sition (Nan	ne of ther place	e)		Date	20c. Loca	tion - City	or Tow		
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Medical Examiner		resulting in death)		Due to	(or as a	consequ										Years	
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9 P. E.	 	resulting in death) Last	ι	Due to	(or as a	consequ	ence of):										
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To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burian	Physician/Medic	23b. Was decedent pregnan in the past 12 months? 1 ☐ Yes 2 ☒ No g ☐ Unknown		23c. If yes, ou 1 Live 4 Prec g Unk	Birth 2 nant at	2 🗌 Fetal	death 3	Ectopic p Other (sp		′			230	d. Date of o		√ day Year	
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/sicia	10 Be	examiner?	-	Hospital:	Innatie	nt 2 🗆 I	ER/Outpatier	t 3 🗆 DC	Other	ce of Deat		me 5 X Reside	ance 6 🗆	Other (Sp.	ocifu)		
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al or Atter s after dea l Director d in by th	Certificate	3 Suicide 6 C	Could not be etermined	28e. Place		ry - At hor (Specify)	me, farm, stre	et, factory	, office			28f. Location (St City or Town		umber or F	Rural R	oute Number,	
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director. After this certificate has completely filled in by the funeral director, page 2.	Medical	(Check 2 Med	ical Examir	ner: On the ba	sis of ex	amination	and/or invest	igation, in r	ny opinior	n, death oc	curred at	nd due to the cau the time, date an ce, and due to th	d place, an	d due to th	e caus	e(s) and manner :	stated.
To th within		29b. Signature and title of co	ertifier	Oli	ノ			29c.	License	number)3139	1	2	gd. Date s	_		y, Year) , 2012	
3	-	30. Name and address of pe			se of de	ath (Item	23a) (Type, P	rint) erick	. Ave	e, Su	ite 4	413, Ga					7
State Registrar		31 Date filed (Month Day V		22.5	-	r's Signati	ure	arke		, , ,		, ,			,		
negistra			V - 41	1 1 ha	1851	- Red	10 · 150	wines									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 40802 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Helen Keefer Adams November 2012 20, 1:05 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Dove House Westminster Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours July 18, 1919 199-09-0089 93 Pennsylvania 1 □ M 2 🔀 **Director** ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Director Maryland Carroll Hampstead 1 🗆 Yes 2 🔀 No 10f Zin Code 10g. Citizen of What Country? 10e. Street and Number Funeral 4010 Highfield Court 21074 United States within 72 hours after death Was Deceud... Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. white If Yes, Give Year or Dates "natural", Completed 3 X Widowed 4 Divorced Medical 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) homemaker own home the Be Department of Health and Mental Hills Important If tiem 27 is marked oth any injury or other traumativ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ruth Freeman Robert F. Keefer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 4010 Highfield Court Hampstead, Maryland 21074 James D. Adams / son 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 ី Cremation 3 🗆 Removal from State Carroll Cremation Hampstead, Maryland 2012 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice Eline Funeral Home 22. Name and Address of Facility M01072 934 South Main Street Hampstead, Maryland 21074 un 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a d Examiner Sequentially list conditions if any, leading to immediate

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Cause (Disease or injury Due to (or as a consequence of) burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregna 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months 1 Yes 2 No Month Year Pregnant at time of death isigned by the a 1 Yes 2 L Unknown Part II. Other grificant conditions contributing to death but not regulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24a. Was an Were autopsy findings available prior to completion of cause of To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director; After this certificate has completely filled in by the funeral director, page 23 autopsy perform death? 2 No 1 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's 2 1 No Hospital 잍 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manne 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury 5 Pending work? 1 ☐ Yes 2 ☐ No atural Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signatul 29d. Date signed (Month, Day, Year) bc

State Registrar DHMH 17 Rev 06-2011 30. Name and address of

strar's Signature

		For State Registrar	State of M	laryland		irtment of H <i>tificate of D</i>		vlental Hy	giene Beg No2	012	40803	
hysicia Medic		1. Decedent's Name (First, Middle Frances C.				_		2. Date of De. Month Novemb	ath	8 2012	3. Time of Death 02:50 PM	
Examin ineral		4a. Facility Name (if not institution 139 Flintstone 5. Social Security Number 221-20-8242	Drive	ge (In yrs. last 78	<i>birthd</i> ay) Yrs.	4b. City, Town, or North If Under 1 Year Months Days		8. Date of Biri (Month, Pa Jan 4	C	g. Birthp Coun Dela	place (State or Foreign try) Ware	
Important: If them 27 is marked other than "natural", or items 29a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	10e. Street and Number 401 Hillcres 11. Marital Status 1 Never Married 2 Ma 3 X Widowed 4 Divorced	Castle t Avenue 12. Was Decedent I Armed Forces? 1	Ever in U.S. No 5+) 20b. Plac	13. W If 13. W If 16a. Deced (Give k life. DC) 19b. Mailin 16 Sp the of Dispose tery, creme Lawn	gton 10f. Zip Code 1980 Vas Decedent of His Yes, specify Cubar Yes 2 K No ent's Usual Occupa ind of work done du 0 NOT use retired) Reception	spanic Origin? (Sp., Mexican, Puerto Specify: Ition Inist 18. Mother's Name Margan and Number or Runce Drive By Jeck Drive	ring ie (First, Middle, cet Jone al Route Number Date Date 2002	United 14. Specific 16b. Kind of 16b. Kind o	n of What Cour ed Stat Race - Americ Black, White, ecify: Whit of Business inc Church name) vn, State, Zip C elaware ion - City or To Castle,	tes can Indian, etc. ite dustry n Code) e 19734 cwn, State , Delaware	
sician/ ledical aminer	Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
ertificate has been signed ector, page 2 should be de	: To Be Completed by Physician/N	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Ves 2 No 9 Unknown 23d. Date of deliver Month 23d. Date o										
To the Funeral Director: After I completed filled in by the funera	Medical Certificate:	27. Manner of Death 1										
Stat Registra		2533 Augustine 31. Date filed (Month, Day Year)	32. Registra	way, St ar's Signature					land	21915		

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 40804 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3<u>0</u> Physician/ 20^{Tear}2 Walter Edward Bizzell 1:50A M Nov. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Charles Waldorf 2894 Stavers Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Social Security Number 7. Age (In yrs. last birthday) Months Min Hours 243 64 1768 Director 1 XM 2 □ F 74 1/24/1938 NC Usual Residence of Decedent show and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Waldorf Charles 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20603 2894 Stavers Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 2 XNo Maryland 21215-0036 Yes 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Black 3

Widowed 4 □ Divorced Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) h and Mental Hygiene.

7 is marked other thar traumatic event, the M Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) Government Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Inez Sutton Eugene Bizzell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2894 Stavers Road Waldorf, MD 20603 Tina C.Bizzell/ Daughter Department of Health Important: If item 27 any injury or other tronce. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 12/4/2012 Beltsville, MD 4 Donation 5 Other (Specify) Chesapeake Crem. 22. Name and Address of FacilityBriscoe-Tonic Funeral Home Old Washington Rd.Waldorf, MD 20601 2294 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Vnina disease or condition Medical resulting in death) Due to (or as a.e Bone and Examiner Metas taris Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a cohsequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours afred death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnal-transit that initiated events sequence of)/ Due to (or as a eq resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 🏹 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 💢 Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending (Month, Day, Year) work?
1 Yes 2 No M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License numb 29d. Date/signed (Month, Day, Year) 29b. Signatu and tit 30 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Collins Sein 3460 Old Washington Road Waldorf, MD 20601

State

Registrar

31. Date filed (Month, Day,

NOV

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Depart		iental Hyg		10005
			Registrar 1. Decedent's Name (First, Middle, Last)	icate of Death	2. Date of Deat	leg. No. 2012	10000
	Physicia		MARK ANTHONY BRINKLEY, JR.		NOVEMBE		3. Time of Death 4:14 A M
	Medic Examin		4a. Facility Name (if not institution, give street and number) 4b	D. City, Town, or Location of Death		4c. County of Death	1
	Funeral		Mo	f Under 1 Year If Under 24 Hrs. onths Days Hours Min.	8. Date of Birth (Month, Day,	9. Birt Year) Cou	hplace (State or Foreign
	Director		213-04-9913 Usual Residence of Decedent 1 X M 2 □ F 31 Yrs.		NOVEMBER	12, 1981WASH	INGTON, D.C.
	ryland -f show ied at	Director	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits 1 ☐ Yes 2 No
	he Ma or 28a e notifi			10f. Zip Code		10g. Citizen of What Co	
	s 23a nust be	Funeral	7900 ANCHOR STREET	20785		UNITED STAT	
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f shoother traumatic event, the Medical Examiner must be notified at	þ	1 Never Married 2 Married 1 Yes 2 No	Decedent of Hispanic Origin? (Specs, specify Cuban, Mexican, Puerto F		14. Race - Amer Black, White Specify: BLA (, etc.
5-0	"natu "natu edical	Completed	15. Decedent's Education 16a. Decedent' (Specify only highest grade completed) (Give kind	's Usual Occupation I of work done during most of workin	ng	16b. Kind of Business/I	ndustry
72	vithin 7 iene. r than	Com	Elementary/Secondary (0-12) 1 YEAR (1-4 or 5+) iffe. DO NO CUSTOME	OT use retired) ER SERVICE ASSOCI	ATE	SHIPPING CO	OMPANY
Maryland 2	uld be filed v Mental Hyg narked othe natic event,	To Be		18. Mother's Name		Maiden Surname) TES BRINKLE	ľ
Man	2 should be the and Mand Mand Mand Mand Mand Mand Mand		1	ddress (Street and Number or Rural			
ē,	f Health item 27 other tra		20a. Method of Disposition 20b. Place of Disposition	ICHOR STREET, HYA		20c. Location - City or	
imo	n 0 = =		1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	ORIAL CEMETERY DEC. 4	4, 2012 V	VALDORF, MA	RYLAND
Baltimore,	permit. Page Department Important: I any injury o once.	ļ,	LYDIA C. THORNTON JOHNSON MO0583 THORN 3439	NTON TONERAL HOM LIVINGSTON ROAD	Œ, PA	N HEAD, MAI	RYLAND 20640
ı			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.			st,	Approximate Interval Between
	Physician/ Medical	2 12	Immediate Cause (Final disease or condition resulting in death) Due to (or = a cors que of of):	ynghohestrocyt	oses		Onset and Death
	Examiner			0 .			
	d Sit	Examiner	Gequentially inst conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):				
	kecute n and al-trans	Exar	Cause (Disease or injury that initiated events c. Due to (or as a consequence of):				****
09	ate be executed ohysician and the burial-transit	dical	d				
687	ertificat ding ph	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy				
Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transition.	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1	otopic pregnancy ther (specify)		23d. Date of deli Month	very Day Year
P.O.	hat the	by Phy		rlying cause given in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
ds, l	quires 1 en sign	d bə			1 □ Y€	es 2 No 3 Pr	obably 4X Unknown
COL	law rec has be e 2 shc	Completed			24a. Was ar autops	sy prior to d	opsy findings available ompletion of cause of
Re	n: The ificate or, pag	e Cor	25. Was case referred to medical	26. Place of Death (Check		med? death? 2 No 1 ☐ Yes	2 🗌 No
Vita	nysicia lis cert l direct	To B	examiner?	Tou		ence 6X Other (Speci	FRIENDS HOME
Division of Vital Records,	ding Ph h. After th funera		27. Manner of Death 28a. Date of injury 28b. Time of injury (Month, Day, Year) injury	28c. Injury at work? M 1 Yes 2 No	28d. Describe ho	w injury occurred	
Sio	Atten er deat ector: by the	Certificate:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street,			reet and Number or Run	al Route Number,
Ω	oital or urs aft rral Dir illed in		building, etc. (Specify)		City or Town		
	n 24 ho n 24 ho ne Fune	Medical	29a. Certifier (Check (Check only one) (Check one) (Check only one) (Check one) (Check only one) (Check o	ion, in my opinion, death occurred at	the time, date an	d place, and due to the c	ause(s) and manner stated.
	To the Vithi		29b. Signature and title of certifier	29c. License number		9d. Date signed (Month)	, Day, Year)
	62		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	MD037292		"128/12	NII I
(20-3		Catherine Broome, MD Georgetown Unive	ersity Hospital W		ervoir Road con, DC 200	•
	Stat Registra	e ir	31. Date filed (Month, Day, Year) 9 2012 32. Segistrar's Signature 9.	Kel	<u> </u>		
			1/7				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40806 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Norman James Billingsley, Jr. Month 11/22/2012ar 7:35 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign Days Hours Director 219-48-9293 64 1 X M 2 □ E May 4, 1948 Washington DC show ifiled within 72 hours after death with the total years. tal Hygiene at other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No Prince George's College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6200 Westchester Park Drive Apt 1108 20740 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Pace - American Indian Black, White, etc. 1 XNever Married 2 Married ģ Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: 3 Widowed 4 Divorced Specify: Caucasian Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Computer Specialist Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Norman James Billingsley, Sr. Jean Carolyn Mowatt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Billingsley/ Brother 13119 11th Street, Bowie, MD 20715 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State Ft. Lincoln Crematory 11/27/2012 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Failure to thrive Medical Due to (or as a consequence of): Examiner severe malnutrition Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. <u>dementia</u> burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician the dria shed for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death Day To the Funeral Director. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🖺 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 욘 1 🗌 Yes 27 No 1 🖾 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Accident 1 🗌 Yes 2 🗌 No Investigation 24 hours after death Funeral Director. Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 only one) 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D60826 11/22/2012 30. Name and address of person who completed cause of death (tern 23a) (Type, Print) E. JM Kshama Garg, 1500 Forest Glen Road, Silver Spring, MD 20910

DHMH 17 Rev 06-2011

State Registrar V 2 9 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 20 State Registrar 40807 dent's Name (First, Middle, La en Blakeney Middle, Last) Helen Helen 2. Date of Death Physician/ Monti 11 16:23 [™] Medical 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Hospital Cheverly Prince Georges Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 578-44-5185 09-02-1932 **Director** 1 ☐ M 2**XX**F 80 Clinton,SC 28a-f show 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits notified MD Prince Georges Bladensburg 1 X Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? must be Completed by Funeral 23a 5999 Emerson St #822 20710 USA 2 should be filed within 72 hours after death . Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. the Medical Examiner Black, White, etc. ò Never Married 2 Married Baltimore, Maryland 21215-0036 1 🗆 Yes 2 No Specify: Black "natural", 3X Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Clerk Government of Health and Mental Hyg item 27 is marked othe other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Bernard Young Lorraine Little 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Timothy Little Son 2200 Margaret Dr. Virginia Beach, VA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Fort Lincoln Cemetery 12/3/2012 Brentwood, MD 21. Signature of Funeral Service Licensee HOI25 BIANCHIES ST NW WASH OC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed physician and sthe burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery Live Birth 2 Fetal death 3 Ctopic pregnancy
5 Other (specify) Pregnant at time of death Day 9 Unknown Division of Vital Records, P.O. ant conditions contributing to death but not resulting in the underlying cause oven in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy perform certificate ha 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To Yes 2 No this Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Investigation Natural s after death. 1 Yes 2 No Accident the Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours a Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month Day, Year

Registrar

State

62:1

me and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month arron 0341 NOY Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death 424 Cuind Silver 50r Moin Omer 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Hours (Month, Day, Year) Director 126-30-2583 1 ⊠ M 2 □ F 72 Yrs. March 14, 1940 item 27 is arked other than "natural", or items 23a or 28a-f show other traus atte event, the Medical Examiner must be notified at 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 424 Windsor Street 20910 USA 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: White If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and 2 should re filed within 72 Health and Mental Hygiene. em 27 is arked other than " Elementary/Secondary (0-12) College (1-4 or 5+) City Planner State Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Frank Barron Rose Dubrowsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian J. Barron/Son 8113 Portwood Turn, Apt. 3, Manassas, VA 20109 permit. Page 1 and 2 Department of Healti Important: If item 2 **Baltimore**, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗆 Burial 2 🔀 Cremation 3 🗀 Removal from State Nov. 28, injury or Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. any 500 University Blvd. Silver Spring.MD 20901 W., 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) m Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami anding physician and use as the buriaktransit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months? Dav Year signed by the at Id be detached for Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been signated Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗖 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed?
☐ Yes 2 N After this certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifical mpletely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Hospital: Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide injury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation М 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 1 Ucritiying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner/10 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Certifying Nurse Practitioners To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number moomE 004

State Registrar 31. Date filed (Month, Day, NOV 2

mo

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRECHER

Year)

9 2012

12-09235 John J Bishop Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene

inn J bishop		1- For State Registrar	State of IV	iaryiano /		tificate of		iu wenta		eg. No. 201	2 40809
Physicia ledical Examir	n/	Decedent's Name (First,							2. Date of Deat Month December		3. Time of Death 1903 hrs
		JOHN JAMES I 4a. Facility Name (if not ins	titution, give stree			4	b. City, Town, o	or Location of D		4c. County of De	
Function		Montgomery Gen 5. Social Security Number	eral Hospital	7 Age	/In vrs la	st birthday)	Olney If Under 1 Ye	ar If Under 2	4Hrs 8 Date of Bir	Montgomery	
Funeral Director		218-32-7682 Usual Residence of Deced	1 ★ M 2	2 F	77	Yrs.	Months Da		Min. 2/27/19	For	eign Country) MD
r any		10a. State 10b. Co			10c. City,	Town or Location	on				10d. Inside City Limits
Aaryland 28a-f show 3 at once.	į		ntgomery		Gaith	ersburg				On Oldinan at Milant C	1 XYes 2 No
h the Mary 13a or 28a 10tified at	Dire	10e. Street and Number 5013 Brookey					10f. Zip Code 20882		1	0g. Citizen of What C USA	
5, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland fealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-fahe traumatic event, the Medical Examiner must be notified at once	y Funeral	11. Marital Status 1 Never Married 2 3 Widowed 4			Ever in U.S	If Y∈		an, Mexican, Pu	? (Specify Yes or No uerto Rican, etc.)	White, etc	erican Indian, Black, .ack
6 72 hours a an "natura ical Examic	leted by	15. Decedent's Education Elementary/Secondary (12th		tes: nest grade com ollege (1-4 or 5	i+)		's Usual Occup est of working lif	e. DO NOT use		16b. Kind of Busines	
-003 I withir giene. Iher th	Comple	17. Father's Name (First, M	iddle Last)		,	raintei	latice we		Apts Name (First, Middle, I	Maintena Maiden Surname)	nce
21215-0036 and be filed within 7 Mental Hygiene. marked other than event, the Medica	8	John James Bi	shop	rint)		19b. Mailing		Elizab	eth Victo	ria Wither	
MD 2 d 2 shoul lith and M n 27 is m		Norma Bishor	/wife			5013 E	3rookev	ille Ro	ad. Gaithe	ersburg, M	D 20882
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and N Important: If item 27 is re		20a. Method of Disposition 1 Burial 2 Crer 4 Donation 5 Oth	nation 3 Re	moval from Sta	te c	Place of Disposi rematory or oth klawn M	er place)		Date 12/11/2012	20c. Location'- City Rockvill	
Baltimore permit. Pages 1 Department of H Important: If i		21. Signature of Funeral &		NO15	76			-		neral nom Rockville	e , MD 20850
Physician /M. dical		23a. Part I. Enter the disea failure. List only one of Immediate Cause (Final di	cause on each line) .		Do not enter the		g, such as card	diac or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and Death
Examiner	-	or condition resulting in de		(or as a conse			· -				
	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Consease or injury that initial	Due to	(or as a conse							
recuted and and and are transit	Exa	events resulting in death)		(or as a conse	quence of):					
60, ite be execi hysician an	Medical	X UNPENDED	AME	NDED23a,	pt.I	[,27,pe	r me,g9	35 1-31	l-13 sm		
		IF FEMALE: 23b. Was decedent pregnar past 12 months?		Live birth Pregnant at		2 Fet	al death 3	Ectopic pr	regnancy	23d. Date of deliver Month	very Day Year
Box e death the atte	hysi	1 Yes 2 No 9	Unknown 9	Unknown							
ires that the signed by	2	Part II. Other significant of Hypertensia				-					to the cause of death?
rds, requires	eted	Chronic Obs	-						24a. Was	an 24b. Were	autopsy findings available
tal Recol	Completed	Liver; Diabe	tes Mell				or	ce of Death (Ch	perfo 1 ✓ Yes	osy prior death 2 No 1	
Vital ysician his cert	To Be	examiner?	Hospita	il: 1 🗹 Inpatie	nt 2	ER/Outpatient		Other		Residence 6 0	ther:
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the safer death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detaced.		27. Manner of Death 1 X Natural 2 Accident		Ba. Date of Inju (Month, Day,Y	ry ear)	28b. Time of Ir	1	jury at Work? Yes 2 No		how injury occurred	
Division or Att ours after de leral Direct filled in by	Certification	3 Suicide 6 4 Homicide	Could not be 2	8e. Place of In	ury - At ho	ome, farm, stree	t, factory, office	building, etc.	28f. Location (or Town, S		Rural Route Number, City
Division To the Hospital or Attent within 24 hours after death To the Fueral Director: completely filled in by the	Medical C	29a. Certifier 1 Certify (Check only one) 2 Medica	i Examiner: On th	o the best of my ne basis of exar manner stated.	/ knowledg mination ar	ge, death occur nd/or investigat	red at the time, ion, in my opini	date and place on, death occur	e, and due to the caus rred at the time, date	se(s) and manner as s and place, and due to	stated. the cause(s)
Haha	¥	29b. Signature and title of			/	(I)		nse number		29d. Date signed (December 5, 2	
		30. Name and address of p					A/ Dalling	- 04 1 5	alkimana BED 04	222	
Sta	ate	Russell Alexande 31. Date filed (Many Lay,		32. gistra	's Signatu	-		e Street, Ba	altimore, MD 21	223	
Regist	гаг	DEC	T A VAIL	LEMAN	~ 1	9. 11	376				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death Physician/ December 201⁸2 EDITH MARIE BROWN 11:10 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 232 1/2 North Potomac Street Hagerstown Washington 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days 213-42-1670 **Director** 1 M 2 M F Oct. 16, 1943 Pennsylvania 69 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marilian Evandia. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1XXYes 2 No Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 232 1/2 North Potomac Street 21740 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. ð 1 Never Married 2 Married ☐ Yes 2 XXNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Completed 3 Widowed 4 Noivorced If Yes, Give Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Waitress Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Harrison Brown Helen Elizabeth Royer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17265 George Statler - Per. Rep. 7705 Upper Horse Valley Rd. Upper Strasburg, PA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1XX Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Cedar Lawn Mem. Park 12-06-2012 Hagerstown, Maryland 21. Signature of uneral Signature 22. Name and Address of Facility Osborne Funeral Home, P.A. 425 S.Conococheague St. Williamsport, MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consec-Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burial-transi burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 X No Month Day 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🗙 No Hospital Other: မူ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide Natural 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatuje and title of certifie

Registrar DHMH 17 Rev 06-2011 30. Name and address of person

who completed cause of death (Item 23a) (Type, Print)

egistrar's Signatur

2012

29d, Date signed (Month, Day, Year)

2174

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OVEMBER Day Mayfield Elizabeth Benge 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Carroll Hospital Center Westminster Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Hours 88 Country. 219-14-8227 **Director** 1 M 2 KF 10/17/1924 MD 28a-f shov 10a, State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director Carroll MD Westminster 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 921 Gahle Road 21157 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ò 1 Never Married 2 Married Black, White, etc. Completed by 1 ☐ Yes 2 🛣 No If Yes, Give Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hyglene. ant: If item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2¾ No Specify: 3 XWidowed 4 ☐ Divorced white Specify: Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Sinai Hospital billing clerk other traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Blanche Pauline Miller Walter Erwin Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
921 Gahle Road, Westminster, MD 21157 Brenda A. Brown, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of h Important: If ite any injury or ot 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mark's Snydersburg 11/24/2012 Hampstead, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Eline Funeral Home Lem Main St., Hampstead, MD 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Inset and Death Immediate Cause (Final Physician/ Par manach Medical resulting in death) Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami attending physician and I for use as the burial-transit death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month signed by the at Id be detached for Pregnant at time of death Day Year 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, cate has been sig ; page 2 should t Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed' this certificate 1 Yes 2 No Yes 2 No Division of Vital hours after death.

Ineral Director: After this certific
by filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After th completely filled in by the funera 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) (10058137 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 307 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

12-09261 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Mary Patricia Robertson State of Maryland / Department of Health and Mental Hygiene AKA: Mary Pa**trois**aia Bridges Certificate of Death Reg. No. 2012-40812 Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Time of Death Month Day December 5, 2012 **Medical Examiner** 1442 hrs Mary Patricia Robertson AKA: Mary Patricia Bridges 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Western Maryland Regional Medical Center Cumberland Allegany If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Months Days Hours Director Country)Maryland 218-80-6096 48 1 M 2 X F August 16, 1964 Usual Residence of Decedent 10a. State 10b. County 10c City, Town or Location 10d. Inside City Limits 1 Yes 2 X No Maryland **Allegany** Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of fleath and Mental Hygiene.
Then I fiten 27 is marked other than "natural", or items 23s or 28s-f sho or other trannatic event, the Modical Examiner must be notified at once. Mount Savage 10e Street and Numbe 10f. Zip Code 10g, Citizen of What Country? ₫ 14123 Upper Sunnyside Road TISA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 X No Yes 4 Divorced If Yes, Give Year Specify: White 3 Widowed 1 Yes 2 No specify: <u>۾</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12 Homenaker Own Home 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Paul David Devore Polana Runions 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21524 ဥ 19a. Informant's Name/Relationship (Type, Print) Jesse A. Bridges-Litten/DGH 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Corriganville, Mary 20c. Location - City or Town, State P.O. Box 303 Maryland crematory or other place) 1 XBurial 2 Cremation 3 X Removal from State 4 Donation 5 Other Specify: Porters Cemetery Dec. 10. 2012 Hyndman, Pennsylvania 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Funeral Home, Inc. Jeromy W. Heeter per dvr 169 Clarence Street, Hyndman, Pennsylvania 15545

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car lac or respiratory arrest, shock, or heart App Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a Complications of a Urinary Tract Infection Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed x AMENDED 21 per fh g937 3-29-13 vt Physician/Medical UNPENDED e attending physician for use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death Live birth 3 Ectopic pregnancy Year Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed l be deta ۵ 1 Yes 2 V No 3 Probably 4 Unknown Completed ficate has been s , page 2 should t 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? 1 🗸 Yes ✓ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other this 1 Yes 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? After 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 V Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 5 Pending 1 Yes 2 No 2 ___ Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide 29a Certifier 1 (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal To the] 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E December 6, 2012 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD 900 W. Baltimore Street, Baltimore, MD 21223 Assistant Medical Examiner 31. Date filed (Month, Day, Year) registrar's Signatur State Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death WEM BER Physician/ 201 Joyce Dwane Carter Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Reeders Memorial Home Boonsboro If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Country) WV Hours 1 □ M 2 💢 F 8/17/1936 216-48-6750 76 Director Usual Residence of Decedent show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location 72 hours after death with the Maryland Director 1 X Yes 2 No Frederick Brunswick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 12 East C Street 21716 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2X No Yes, Give Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: 3 X Widowed 4 Divorced White Year or Dates. 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) and 2 should be filed within Sales Clerk Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Dora Bell Davis George William Carper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy Escamilla, Daughter 12 East C Street, Brunswick MD 21716 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/28/2012 Hagerstown Crematory Hagerstown MD 21. Signature of Funeral Service Livense 22. Name and Address of Facility John T Williams Funeral Home, Brunswick MD 21716 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, ir any, reading to immediate cause. Enter Underlying Physician/Medical Examiner that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No signed by the atte Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Multiple Scless 5 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, To the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Tunknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No has After this certificate within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, t 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 2 No Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Investigation Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature an 149996 Name and address of person who completed cause of death (Item 23a) (Type, Print) 20311 KOAD 32. R gistrar's Signature 31. Date filed (Month) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 40814 Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5:20 P 2012 MICHAEL CHIOMENTI November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7318 Granalta Circle Frederick Frederick If Under 1 Year I If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours (Month, Day, Year) Days Min Director 120-12-3770 1 対 M 2 □ F Yrs Nov. 5, 1917 NY 95 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "netural", or Items 23e or 28a-f sho the Medical Examiner must be notified at within 72 hours efter death with the Maryland Director 1 ☐ Yes 2X No Frederick MD Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7318 Granalta Circle 21702 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ğ 1 Never Married 2 X Married 1 X Yes 2 ☐ No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify. Specify: White Completed 3 Widowed 4 Divorced Year or Dates. 1941-45 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) end Mental Hyglene. Is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 4 accounting accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be Giovana Costanzo Peter Chiomenti other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shr Department of Health en Importent: If item 27 Is eny injury or other traus Lydia Chiomenti/wife 7318 Granalta Circle, Frederick, MD 21702 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 😾 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Stauffer Crematory 11/27/2012 Frederick, MD 21. Signature of Juneral Service Livers 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death WESLS Immediate Cause (Final metastatic Physician prostate cancer Medical resulting in death) Due to (or as a consequence of) Éxaminer Sequentially list conditions, if any, leading to immediate cauca. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami ettending physician end I for use es the buriel-transit or Attending Physician: The law requires that the death certificete be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year 4 Pregnant at time of death Day sate has been signed by the e page 2 should be detached i 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Division of Vital Records, Pheumonia 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funaral Director. After this certificate I completely filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 2 Accident Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. 11-27-2012 72480 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3+1VA Opossumtom Pike Frederick, MD Lowen 1564 E. JASON 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 29 2012 arke Registrar CARLELAND.

40815 State of Maryland / Department of Health and Mental Hygieney 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary Evangeline Cord November 28 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Charlotte Hall 8365 Roundhill Road Charles If Under 1 Year Jf Under 24 Hrs 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 579-09-6730 Director 1 🗆 M 2 🛛 F 92 Yrs. Maryland 09/21/1920 Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at Director 1 Yes 2 No Charlotte Hall Marvland Charles 10f. Zip Code 10g. Citizen of What Country? Street and Number Funeral USA 20622 8365 Roundhill Road 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. "natural", or iten edical Examiner 11. Marital Status þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X ☐ No Specify: If Yes Give Specify: White 3 ₩ Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Ith and Mental Hygiene. 27 is marked other than "r r traumatic event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Florence Chrismond John Jameson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i 5800 Avondale Drive Bowie, Maryland 20715 <u>Rena Judy/ Daughter</u> Department of Healtl Important: If item 2 any injury or other tonce. Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Fort Lincoln Cemetery 12/01/2012 Brentwood, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Huntt Funeral Home . Signature of Funeral Service Lice 3035 Old Washington Road Waldorf, Maryland 20601 Enter the disease, or complications that valued the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. 23a. Part 1. shock Interval Between Onset and Death Immediate Cause (Final Physician/ AWCRI disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events burial-tran Due to (o resulting in death) Last equence of attending physician Physician/Medical 68760 IE FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box (3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 Yo
9 Unknown jo. Month Day Vear Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: ဂ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred or Attending 1 Natural 5 Pending Accident Suicide Investigation thin 24 hours after deat the Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier o the Howithin 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatur and title of certifier 29d. Date signed (Month, Day, Year) of dea th (Item 23a) (Type, Print) 2060 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Yong Cho November 2012 9:31 a^{M} Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Medstar Montgomery Medical Center 01ney Montgomery Social Security Number 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Country) 213-76-2600 **Director** 1 🖾 M 2 🗆 F 82 Dec. 1, 1929 Korea Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location with the Maryland must be notified at 10d. Inside City Limits Director MD Howard 1 Yes 2 XNo Laurel ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 9895 Palace Hall Drive 20723 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces 10 Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any fujury or other traumatic event, the Medical Examin onee. Completed by 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Asian 3 Widowed 4 Divorced If Yes, Give Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4 or 5+) Carpenter Construction Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Cho Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baek Cho/Wife 9895 Palace Hall Drive, Laurel, MD 20723 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Nov. 2012 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 20, Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD 21. Signature of Funeral Service Licen Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): ng physician and e as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ signed by the atter in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 1 Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did to cco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No **Division of Vital** filled in by the funeral director, 25. Was case referred to To Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 1 Inpatient 2 A/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar DHMH 17 Rev 06-2011 only one)

General

Montdoney

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Frances Lucille CROMER November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Meritus Medical Center Hagerstown Washington 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 214-09-4388 92 Director 1 🗆 M 2 🔀 F Nov.3, 1920 Maryland ortent: If item 27 is marked other then "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Smithsburg 1 ☐ Yes 2 No 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 13 Blue Mountain Estate 21783 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Specify: 3 Widowed 4 Divorced If Yes, Give WHITE Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h h and Mental Hygiene. 7 is marked other then "n Elementary/Secondary (0-12) College (1-4 or 5+) blueprint attendant aircraft mfg. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Harry Clegette Lehman Beulah Mabel Trumpower permit. Page 1 and 2 should I Department of Health and Me Importent: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print)daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 W. Douglas Court, Smithsburg, Maryland 21783 Lucinda Clevenger Cosens 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛣 Burial 2 □ Cremation 3 □ Removal from State Rest Haven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 12/6/12 Hagerstown, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Que to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the buriel-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed?
☐ Yes 2 ☐ N 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 1 No Other: ၉ 1 Inpatient 2 PER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature 29c. License number 366 VI se of death (Item 23a) (Type, Print) TW-5 MIN

DHMH 17 Rev 06-2011

State Registrar

Maryland 21215-0036

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40818 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Monte Patricia Sue Coakley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** County of Death Harford Harford Memorial Hospital Havre de Grace 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. 1 M 2 Ty F Hours 107224 1935 215-32-3915 77 Alabama **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hyglene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c, City, Town or Location 10d. Inside City Limits Director Harford Maryland Havre de Grace 1 X Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 704 Giles Street 21078 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married þ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ▼ No Specify: Specify: White Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Cost Accountant Civil Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Patrick Powell Arvie Kerr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arthur Coakley (husband) 704 Giles St. Havre de Grace, Maryland 21078 20a Method of Disposition 20b. Place of Disposition (Name of ^{20c. Location} - City or Town, State West er . cemetery, crematory or other place of RA Ferris & Co Page 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 12/08/2012 4 Donation 5 Other (Specify) Pennsylvania 21. Signature of Funcial Service Licens 22. Name and Address of Facility Zellman Funeral Home, P.A. -6 Washington St. Havre de Grace, 123 S. 23a. Part 1. Enter the discse, or complications that caused the death. Do not enter the mode of dying, such Approximate shock, or heart failure. List only one cause on each line. terval Retween Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) 1 Yes 25 signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Unknown Récords, Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has e 2 death? 2 No NO NO Yes 1 🗌 Yes 25. Was case referred to medical Vital 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Division of 27. Manner of Death Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) work? Natural 2 Accident injury To the Funeral Director: Aft 5 Pendina 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Exprisor: On the best of exprisorious and/or investigation in my opinion death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and titl 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Lessie L. Davis 26, 2012 6:00 Nov<u>ember</u> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Suburban Hospital Bethesda If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours Director 248-52-8095 1 M 2 X F 91 Sept. 28, 1921 South Carolina Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🛛 Yes 2 🗆 No Cheltenham Prince George's Maryland 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20623 10207 Farrar Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Government 12th Custodial Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည unk. Eutrice Monroe Darby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10207 Farrar Aveune Cheltenham, Maryland Vivian Davis- Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cantal) crematory or other place Pilorim Baptist Church Cemetery 20c. Location - City or Town, State Dec. D89 2012 4 ☐ Donation 5 ☐ Other (Specify) Chester, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. Stewert 4001 Benning Road NE Washington, DC 20019 M00560 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ Respiratory Failure disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Pneumonia Sequentially list conditions, Examiner if any, leading to immediate cause. Ener Underlying Cause (Disease or injury Due to (or as a consequence of) executed physician and s the burial-trans Dementia that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown ed by the a 9 Unknown P.O. signed by t d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be lirector, page 2 s autopsy perforn 2 🔣 No Yes 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 ☐XNo မြ 1 Main Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death . Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending Investigation 2 🗌 3 🔲 Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 29a. Certifier 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the only one 29b. Signatu d title of certifie 29d. Date signed (Month, Day, Year) November 28, 2012 D70241

Registrar
DHMH 17 Rev 06-2011

State

8600 Old Georgetown Road Bethesda, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Shanthi Nadar, MD

1			Pleas	e Type or Pri									ible.	
N. W.	State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra MEND#23a(a) 6erMD, 11/19/12; EMW, MoCo Certificate of Death Reg. No.													
C. C.	Physic	ian/	1. Decedent's Name (First, Middle, La	ast)						2. Date Mon	of Death		Year	3. Time of Death
(4)	Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death											Day Year 8.40 AM 4c. County of Death		
N	Sex 7 Age (in was last hirthday) If Under 1 Year If Under 24 Hrs 0 Detect 1 Hrs 0 Det												tgom	
11	Director 217-15-5189 1 DM 2 DF Yrs. Months Days Hours Min. (Month, Day, Year)											2/	Cour	**
1	and show	ō	Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or	Location			-1	211-)(Rus	Sia Od. Inside City Limits
B.	r 28a-f	Direc	Maryland Montgo	omery		Rocky								1 ☐ Yes 2 Å No
The	101. 2p code 10g. Citizen of											. Citizen of W Jnited	hat Cour Sta	tes
In.	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forcey? If Yes, specify Cuban, Mexican, Puerto Rican, etc.)												- Americ	an Indian,
300	1 Never Married 2 1 Married 1 Yes 2 No 1 Yes Specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No 1 Yes Specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify													ite
7/10 25	in 72 ho e. nan "na	mple	15. Decedent's (Specify only highest g	rade completed)	.\	(Gi	ve kind of u	sual Occup work done o use retired)	ation during most of w	orking	161	o. Kind of Bu	siness/In	dustry
1/1/2	Hygien Hygien other th	Be C	17. Father's Name (First, Middle, Last)	College (1-4 or 5		Pr	ofess	sor				Univ		<u>ty</u>
0849 Am "Baltimore. Marvland	ld be fill Mentel arked c	[2	Ilja Dragunsky			_			18. Mother's N Elena	^{lame} (First, M Golubk	iddle, Maid (OVa	len Sumame)		
Mar	2 shou Ith end 27 Is m treum	ı	19a. Informant's Name/Relationship (Eugenia Dragunsky	** * *					and Number or F					
1840 A.	e 1 end 2 sof Heelth If item 27 or other tra	1	20a. Method of Disposition 1 ☐ Burial 2 Å☐ Cremation 3 ☐		20b. F	Place of Dis	oosition (N		- 1	Date		Location - 0	208 City or To	
% Itim	permit. Pege 1 Depertment of Important: If is any injury or o		4 Donation 5 Other (Spec	rify)		ropol	itan	Crema	atory 11			lexan	dria	, VA
Ba	Dep Imp		21. 31 alte of Vorte at Service Licer	isee	MOI				≈∘Hedurew II St.,				DC :	20012
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0	Pnysician/ Medical Examiner		disease or condition resulting in death)	a. Due to (or as a	$-\kappa$	soht	- In	trac	Crania	l He	mor	rhage	2	Onset and Death
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68760	certificete be nding physici use as the bu	/Med	IF FEMALE:									T		
N/S	i iii	Physician/Medica	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at	Peta	death 3	☐ Ectopi	c pregnancy (specify)	у			23d. Date Mont		ry Day Year
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S, 11/2	requires the	Completed by				ourig in the	- undertying	g cause give	en in Fait i.					e cause of death? ably 4 🔽 Unknown
W Prope	has bee	mple									Was an autopsy	pri	or to con	sy findings available
41 C	Physician: The lew this certificate has ral director, page 2 a	Be Co	25. Was case referred to medical		_		_	26 Pla	ice of Death (Chi	111	performed? Yes 2/L	No 1	ath? Yes :	2 □ No
VNSK f Vital	Physici this cer al direc	요	examiner? 1 Ly Yes 2 L No 27. Manner of Death	Hospital:				DOA Other	r: 4 Nursing		Residence	6 ☐ Other	(Specify)	
S OF OF	or Attending sefter death, Director: After In by the fune	licate	1 X Natural 5 ☐ Pending 2 ☐ AccidentInvestigation		Year)	28b. Time injury	of M	28c. Injury work? 1 ☐ \		28d. Descr	ibe how inj	ury occurred		
Division	lor Atte efter de Directo	Certificate:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		y - At hor (Specify)	me, farm, s	treet, facto	ry, office			on (Street a Town, Sta		or Rural I	Route Number,
VD	To the Hospital or Attending Physician: The lew requires that the deswithin 24 hours effer death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Medical (29a. Certifier 1 Certifying Physic (Check 2 Medical Exam	sician: To the best of m	y knowle	edge, death	occurred	at the time,	, date and place,	and due to ti	he cause(s)	and manner	as state	i.
	To the P. Vithin 2. To the F. Complet	ğ	only one) 3 Certifying Nurs	iner: On the basis of exa se Practitioner: To the	best of m	knowled	e, death oc	or my opinion ocurred at the Oc. License	in tierrier, datel and	at the time, d	e to the cau	Se(c) and man	iner as st	sted.
	V		▶ #W	Jim Tr	an	DO		H70	127		11	ate signed (012	ıy, 1ear)
			30. Name and address of person who o	completed cause of dea	0	23a) (Type, M <i>ON</i> () .	3600 0	old Geor Jourba	getown	Rd.	Beth	esda	, MD 20814
	Sta		31. Date filed (Month, Day, Year)	37. Registrar			-	سام	warba	N DO	ווענים	~		
100	Registra	ar	NOV 1 9 201	L Chrown	ß.	1900								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 11/21 2012 Year Philip Singer Day 8:15 Ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5800 Connecticut Ave Chevy Chase Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Funeral 9. Birthplace (State or Foreign Min. (Month, Day, Year) Hours Director 005-28-9257 1X M 2 G F 79 10/05/1933 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits FLNaples 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1041 Oriole Circle 34105 USA 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1X Never Married 2 Matried Black, White, etc. þ 2 No 1 Yes Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hyglene. ant: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Attorney L<u>aw</u> æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph P. Day Pauline Singer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 53 Main ST,P O Box 200, Castine Maine 04421 James M._Day / Brother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of 1 Burial 2 X Cremation 3 Removal from State Important: I any injury o National Crematory 4 Donation 5 Other (Specify) 11-28-2012 Falls Church, Va 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons M00063 5130 Wisconsin Ave NW Washington DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 1 Yes Other: 4 \(\text{Nursing Home} \) 1 Nursing Home 5 \(\text{Aresidence} \) 1 Residence 6 \(\text{Other} \) Other (Specify) ၉ 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 ☐ Yes 2 ☑ No Sel 5-17 えいか りかつ Investigation 21 2012 3 Suicide 6 Could not be 28f. Location (Street and Number State) 5 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined City or Town, State) 5 Home Cheux mo Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of ce D00428 Om B 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 23 mo, DME State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2012 40822

		1- For State Registrar		Cert	ificate of	Death		Re	eg. No.			
Physicia ledical Examin			DELLER		-			2. Date of Deat Month December	Day Year	3. Time of Death 1416 hrs		
)		4a. Facility Name (if not institution Upper Chesapeake M	-	umber)	4	b. City, Town, or Bel Air	Location of Deat	h	4c. County of Harford	4c. County of Death Harford		
Funeral Director		5. Social Security Number 203-52-5561	6. Sex	7. Age (In yrs. las		If Under 1 Year Months Days			th(MM/DD/YYYY) 0,1960	9. Birthplace (State or Foreign Penna.		
th the Maryland 23a or 28a-f show any notified at once,	Director	Usual Residence of Decedent 10a. State			Fown or Location	10f. Zip Code		10	0g. Citizen of Wha	10d. Inside City Limits 1 Yes 2 No at Country?		
2 hours after death wi "natural", or items	Completed by Funeral Di	11. Marital Status 1 xx Never Married 2 Mi 3 Widowed 4 Div 15. Decedent's Education (Spe- Eiementary/Seconoary (0-12)	arried Armed F 1 Yes orced If Yes, Give Ye or Dates: cify only highest gra	2 X No er	If Ye	Decedent of His is, specify Cuban Yes 2 No S Usual Occupation of working life.	Mexican, Puert specify: on (Give kind of	work done	Specify:	White		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Com	17. Father's Name (First, Middle, Philip A. Dell	,		•			e (First, Middle, N	Maiden Surname)			
MD 212 d 2 should b lith and Men n 27 is marl	To	19a. Informant's Name/Relations Janice B. Cros	hip (Type, Print)	Mother			and Number or	Rural Route Num		, State, Zip Code) MD 21132		
Baltimore, I bernit. Pages I and Cepartment of Heall Important: If item injury or other tra		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20a. Method of Disposition (Name of cemetery, crematory or other place) White Rose Crematorium Dec. 8, 20c. Location - City or crematory or other place)										
Balti Bermit. Departe Import		4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee 22. Name and Address of Facility Geiple Funeral Home Inc. 53 Main St Glen Rock, 73a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart										
/Medical xaminer		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line. a. <u>Gastro</u>	intestina consequence of):	al Hemo					rt Approximate Interval Between Onset and Death		
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b. Due to (or as a	a consequence of):		··· <u></u>						
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760, cate be executed physician and he burial - transitions.	g	X UNPENDED	AMENDED	23a,pt.II	,27,pe	r me,g93	4 12-28	-12 sm				
ox 68 ath certificant certificant attending or use as t		IF FEMALE: 23b. Was decedent pregnant in th past 12 months? 1 Yes 2 No 9 Unk	1 Live t	outcome of pregna birth nant at time of deat own	2 Feta	al death 3 [er (Specify)	Ectopic pregn	ancy	23d. Date of o	delivery Day Year		
P.C.	<u>a</u>	Part II. Other significant conditions Coronary Arter								oute to the cause of death? Probably 4 Unknown		
	Completed	End Stage Kic		ase; Hist	ory Of 1		Cancer		sy pr m <u>ed</u> ? de	ere autopsy findings available ior to completion of cause of sath? Yes 2 No		
Vitalysiciae	o Be	examiner? 1 ✓ Yes 2 No	Lie emiteix	Inpatient 2 🗸 E	R/Outpatient	I	Other -		Residence 6	Other:		
ion of tending Ph eath. lor: After t	┺┢	27. Manner of Death 1 X Natural 5 Pend	28a. Date (Month		28b. Time of Inj	ury 28c Injur	y at Work? es 2 No		now injury occurre			
Divis pital or At ours after d ieral Direct filled in by	1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined Phonicide Suicide 6 Could not be determined (Specify) 2 Accident Suicide 6 Could not be determined (Specify) 2 Suicide 6 Could not be determined (Specify)											
	252. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	Σ	29b. Stantature and title of certifie	herry 1			29c. License O.C.M			29d. Date signe December 7	d (Month, Day, Year) 7, 2012		
0		30. Name and address of person Laron Locke MD. As	who completed caussistant Medica			timore Street	Baltimore	MD 21223	<u> </u>			
Sta Registra		31. Date filed (Month, Day, Year)		egistrar's Signature			, Dallinore,	2 1220				
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 40823 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year Anastasia Rita Douglas 201 Medical <u>necembe</u>r 4:30 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 900 Prentiss Rd. Charles Waldorf 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) Months Days Hours Director 197-34-5997 1 □ M 2 과 F 71 Vrs 11/27/1941 Pennsylvania 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 900 Prentiss Rd. 20602 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify. 3 Widowed 4 Divorced Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiana. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 1 and 2 ahould ba filad w of Haalth and Mantal Hygi fitem 27 le marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph John Sterback Elizabeth Emily Eagler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph H. Douglas/Spouse 900 Prentiss Rd., Waldorf, MD 20602 other! 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If II any injury or o 1 Burial 2 Dermation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/12/12 Alexandria 22. Name and Address of Facility Raymond Funeral 21. Signature of Funeral Service Lignage Service, P.A M01517 5635 Washington Ave., La Plata, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the *m*ode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ an disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Exami Aftar this cartificata has baan signad by the attanding physician and funaral director, paga 2 should be datached for usa as tha burlai-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performer 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) nours after death. neral Director: After this co y filled in by the funaral dire 1 ☐ Yes 2 No.No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pi within 24 hours aftar daath. To the Funeral Director: Aftar th compiataly filled in by the funara Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural
2 Naccident
3 Suicide 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certif 30. Name and address of person who completed cause of death (Item 3a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12:50 P _M Physician/ Norma Pauline Etzler November 19, 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Citizens Care & Rehab. Center Frederick Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Days Min. (Month, Day, Year) Hours **Director** 215-18-1190 1 🗆 M 2 🔯 F 93 June 30, 1919 Maryland Maryland or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Frederick Frederick 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5714 Box Elder Court 21702 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, δ Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 X Widowed 4 ☐ Divorced If Yes, Give Completed Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 2 should be filed within 72 l th and Mental Hygiene. ?7 is marked other than "r (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Nurse <u>Healthcare</u> permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any Injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Paul Etzler Norma Virginia Wachter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Jim Downing/ Personal Rep</u>. 14125 Bear Creek Drive, Boyds, Maryland 20841 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 11/24/2012 Smithsburg, Maryland 21. Signature of Funeral Service Licenses Keeney & Bastord P.A. Funeral Home 106 E. Church Street, Frederick, MD 21701 K. Bol MO1646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final arteriosel Onset and Death Physiciani cardiosaso. disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director After this certificate has hear solved. attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Month Day After this certificate has been signed by the a funeral director, page 2 should be detached t 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ♣No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No after death.

Director: After this certifice 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: Other: 42 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1709689 ustin November 19, 2012 00015 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 Austin Pearre. MD 300 W. 9th Street, Frederick, Maryland 21701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 30 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 015 M KHOF Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Mandrin In-Patient Care Center Harwood Anne Arundel If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Hours Min. (Month, Day, Year) 146-40-8879 Director 1**X**□ M 2 □ F 65 Usual Residence of Deceden May 6, 1947 New Jersey or 28a-f show or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Crofton 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1519 Fenway Road 21114 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 X Married Black, White, etc. ≥ Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white Completed 3 Widowed 4 Divorced Year or Dates. 67-73 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 end 2 should be filed within 73 Department of Health and Mental Hygiene. Importent: If frem 27 is marked other than 'eny injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 12 Police Officer Law Enforcement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Eckhoff Evelyn Schuermann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria Eckhoff - wife 1519 Fenway Road, Crofton, MD 21114 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Kemoval from State 4 ☐ Donation 5 ☐ Other (Specify) NJ Veterans Cemetery 11/29/2012 Arneytown, NJ 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home MO0544 16000 Annapolis Road, Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Onset and Death disease or condition resulting in death) UN. 6 Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physicien: The lew requires that the death certificate be executed Cause (Disease or frijury for use es the burial-tran that initiated events resulting in death) Last end Due to (or as a consequence of): ettending physiclan Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month signed by the et Id be detached fo Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by RANGE LETOVAM 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen OSURE IST WICBOMBING Was an 24b. Were autopsy findings available prior to completion of cause of death? this certificate has performed? Yes 2 No 1 🗌 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 ☑ No |은 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of After t 28c. Injury at 28d. Describe how injury occurred 5 Pending work?
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neral Director: Afilled in by the fu 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital o within 24 hours af To the Funeral Di completely filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or invention to 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one Signature and title of certifier 21438 Name and address of person who completed cause of death (Item 23a) (Type, Print) EN V 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2012 40826													326		
			Registrar Decedent's Name (First, Middle, Last	st)	Oei	tincate of t	Dealii	2	. Date of Dea	109.110.	-	3. Time of			
	Physicia Medic		RUTH ELLEN	EGGER					Month	Day	Year 2012	1:41	Рм		
	Examir		4a. Facility Name (if not institution, give	street and number)		4b. City, Town, o	r Location c	of Death			y of Death	1 1 1 7 1			
- June			12654 Balte Road			Ocean (Wo	rcest	er			
	Funeral Director		212-40-9454	ex 7. Age (In yrs. 70	last birthday) Yrs.	If Under 1 Year Months Days	If Under	Min.	Date of Birtl (Month, Day INE 26	Yea <i>r</i>) 1942	g. Birth Coun MARY	place (State of htry) LAND	r Foreign		
	at at	ě	Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ity, Town or Lo	cation				69.60	1.	I 0d. Inside Cit	v Limits		
	/anyla 8a-f s tified	Director	MARYLAND WORCES	rer oc	EAN CI	TV						1 🗆 Yes			
	the N	١	10e. Street and Number	7 00	JERN OI	10f. Zip Code				10g. Citizen of	What Cour	ntry?			
	h with nust I	Funeral	12654 BALTE ROAI)		21842				USA					
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🎇 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates.	l i	Vas Decedent of H f Yes, specify Cuba	an, Mexican	, Puerto Ric	Yes or No- an, etc.)	Yes or No- an, etc.) 14. Race - American Black, White, et Specify: WHIT					
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ă	be fill ental ked c	인	JOHN ADKINS			18. Mother's Name (First, Middle, Maiden Surname) ELIZABETH HILYARD									
ary	hould and M s mar umat		19a. Informant's Name/Relationship (T)	City or Town, S	State. Zin (Code)									
Σ	nd 2 sl salth a n 27 i		DAWN L. PRUITT/DAU	JGHTER		L TURTLE									
ore	of He of He if item ir oth		20a. Method of Disposition 1 T Burial 2 □ Cremation 3 □	Paracual from State	Place of Dispos	sition (Name of natory or other place		Date		20c. Location					
Ĕ	Page ment tant: I		4 ☐ Denation 5 ☐ Other (Specif	SUN		MORIAL PA		11/30	/12	BERLIN,	, MAR	YLAND			
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Livers	BYVILLE	E, DE	19975									
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	Medical Examiner		resulting in death) Due tr (or as a consequence of):												
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876	ifficating phases the	Med	IF FEMALE:												
. Box 68	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi	Physician/M	and the past 12 months? In the past 12 months? I ☐ Yes 2 🗷 No g ☐ Unknown	23c. If yes, outcome of pregna 1 Live Birth 2 Feta 4 Pregnant at time of g Unknown	al death 3 🗔	Ectopic pregnanc Other (specify)	y				ate of delive	. ,	ear		
л О	that ined b	by P	Part II. Other significant conditions co	ntributing to death but not res	sulting in the ur	nderlying cause giv	en in Part 1.		23e. Did tob	pacco use cont	ribute to th	e cause of de	ath?		
ds,	quires en sig ruld b	bel							1	es 2 🗆 No	3 Prob	ably 4 🗆 U	nknown		
Vital Records,	The law ate has page 2	Completed							24a. Was ar autops perform	med?	Were autop prior to con death? 1 Yes	psy findings av	ailable use of		
<u>e</u>	cian: ertific ector,	Be	25. Was case referred to medical examiner?	Hospital:				h (Check onl							
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on of	tending leath. or: After the funer	Certificate:	1 Mahrel 1 Death 1 Mahrel 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work' M 1 🗆	rat ? Yes 2□t		. Describe ho	w injury occurre	ad				
DIVISION	tal or At irs after c al Direct ed in by		4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stre	et, factory, office		28f.	Location (Str City or Town	reet and Numbe , State)	er or Rural i	Route Numbe	r,		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2 \sqcup Medical Examin	ician: To the best of my know her: On the basis of examination e Practioner : To the best of m	n and/or investig	gation, in my opinio	 n. death occ 	curred at the	time date and	d place and due	e to the cau	se(s) and manu	ner stated.		
	or with	29b. Signature and title of pertifier N.O. 29c. License number 29d. Date signed (Month, Day, Year) N.O. 27, 2012													
)	DIC		80. Name and address of person who co	propleted cause of death (Item	23a) (Type, Pr										
	State Registra	~	1. Date filed (Month, Day, Year) 20	32 Registrar's Signat		Aland					,				
				100	37	-									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40827 1-State
Registrar Amend #1 Per FH JM 11/2 Sertificate of Death 1. Decedent's Name (First, Middle, Last)

Ganiat Abeni Folarin-Enifeni 2. Date of Death Physician/ Month Year 212 3:11 (PM) Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** University of Maryland Medical Center Baltimore Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 578-74-7329 **Director** 1 M 2 XF 05/04/1947 Nigeria 65 Usual Residence of Deceden 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County must be notified at Director 1 X Yes 2 No Baltimore City Baltimore MD 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral **AZU** 3205 Baker St. 57576 items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. or. þ 1 Never Married 2 X Married within 72 hours after Maryland 21215-0036 1 Yes 2 X No Specify: "natural", Specify: Black 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Transportation Cab Driver traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Department of Health and Mental Important: If Item 27 is marked to any injury or other traumation. ပ Banjoko Atinuke Bisiriyu Enifeni 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3205 Baker St., Baltimore, MD 21216 Tope Adeduro / daughter altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State cemetery, crematory or other place) Heritage Memorial Cem. 11/30/2012 Waldorf, MD 4 ☐ Dopation 5 ☐ Other (Specify) 22. Name and Address of Facility Strickland Funeral Services 21. Signature.c Funeral 5 6500 Allentown Rd⋅₁ Camp Springs, MD 20748 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a confiquence of): distress day disease or condition Medical resulting in death) Examiner neumonia Sequentially list conditions, Examiner Due to for as a consequence of if any, leading to immediate cause. Enter Underlying -transil Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Rena certificate be MIUN Division of Vital Records, P.O. Box 68760 F FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Hypertension 1 Yes 2 No 3 Probably 4 Onknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an page 2 s autopsy has Hospital or Attenting Physician: The 24 hours after death.
 Funeral Director: After this certificate. Yes 2 No 25. Was case referred to medica funeral director, 26 Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ျှ 1 Inpatient 2 ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) Certificate; 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred iniury 5 Pending Natural To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) 29c. License number 11 JP1. 18515

State Registrar 31. Date filed

25M

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DHMH 17 Rev 06-2011

south Greene J. Buttomore, MD 2120,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DU

Registrar's Signature

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Please	Type or	Print in	Black In	idelible Ink.	Ensure All	Copies	Are	Legible
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State of Maryland / Department of Health and Mental Hygiene 2012 40828 1- For State Certificate of Death Reg. No Registrar Physician/ . Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death **Medical Examiner** November 26, 2012 2134 hrs William J. Francis II 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Port Deposit Cecil 914 Craigtown Road **Funeral** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Months Days Hours Min Director Country) 1X M 2 F 7/8/1948 Yrs 64 PA 196-40-0413 Usual Residence of Decedent 10d. Inside City Limits 10a State 10h County 10c. City. Town or Location 1 Yes 2 X No or items 23a or 28a-f show must be notified at once. rmit, Pages I and 2 should be filed within 72 hours after death with the Maryland partment of Health and Mental Hygiene.

pportant: If item 27 is marked other than "matural", or items 23a or 28a-f sho MD Cecil Port Deposit Directo 10e. Street and Number 10g. Citizen of What Country 914 Craigtown Rd. 21904 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14, Race - American Indian, Black, Armed Forces? White, etc. 1 Never Married 2 Married 1 X Yes 3 X Widowed 1 Yes 2 X No specify If Yes, Give Year white 4 Divorced Specify: event, the Medical Examiner ğ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 12 Tech<u>nician</u> Communication 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be William J. Francis Stephanie Dardzinski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1310 River Oaks Dr. Unit 2M
Myrtle Beach, SC 29579 item 27 is <u>Joan Creekmore/stepdaughter</u> 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition ltimore, 1 X Burial 2 Cremation 3 Removal from State crematory or other place) 12/14/12 Washington Crossing Donation 5 Other Specify Newtown, PA 21. Signature of Funeral Service Licentee 22. Name and Address of Facility
R.T. Foard Funeral Home, P.A. our 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart MD 21911 Approximate Interval Physician Between Onset and /Medical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease 'xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner eauss. Enter Underlying Causs (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical attending physician for use as the burial -UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Year Fetal death Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) for 1 Yes 2 No 9 Unknown Unknown the signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 Yes 2 No 3 Probably 4 V Unknown Completed 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed death? page certificate Yes 2 ✔ No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funcral Director: After this certifi director, 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other Nursing Home 5 Residence 6 🗸 Other: Scene DOA Inpatient 2 ER/Outpatient 3 1 Yes 28a. Date of Injury (Month, Day,Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural 1 Yes 2 No Pending Investigation 2 ___ Accident filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined 4 Homicide (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 27, 2012 36 Name and address of person who complete ause of death (Item 23a) YTIVA Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31 Date filed (Month, Day, Year) 32. Registrar's Signature State Registra

DHMH 17 Rev 1/2001 OCMF 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene L0829 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Day 18,201 November 1855 Charles Lewis Franks Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days (Month, Day, Year) Hours Director 243-72-6585 1 □XM 2 □ F 63 Feb.5,1949 Usual Residence of Deceden 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Hyattsville PG MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20781 5611 Decatur Place United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ò 1 Never Married 2 X Married 1 X Yes 2 □ No If Yes, Give 1 Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. 3 Widowed 4 Divorced Completed Year or Dates. Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry المالم filed with. عام Hygiene. مال Than "r (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Chief Warehouse Supervisor VA Hospital Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o ပ Isaac Franks Annie L. Wooten 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Place Decatur tsville 1 and 2 s if Health a item 27 i Audrey Franks/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 11/28/12 1 № Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Franks Family Cemetery Mayesville, NC 21. Significe of Funeral Service Licenses 22. Name and Address of Facility Hodges & Edwards F. H. 3910 Silver Hill Rd., Suitland, MD. 20746 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death , or heart failure. List only one cause on each line Immediate Cause (Final disease or condition SEPTIC Pnysician Medical resulting in death) Due to (or as a consequence of): Examine ORGAN DYSFUNCTION MULTIPLE Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami signed by the attending physician and d be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Physician: The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed this certificate has been siral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1No 1 Inpatient 2 I ER/Outpatient 3 I DOA မူ funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred After t Natural 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu 1 ☐ Yes 2 ☐ No death. Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one 29b. Signature and title of certifier 29c. License number 11/19/2012 MAMIN

7+1 5x

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day Year) 2012

rison who completed cause of death (Item 23a) (Type, Print)
ANNUM WASATINGTON MOVENTUT HOSP, TAKOMA PROK, HD-ZOG12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 40830 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 11/28/1 Physician/ Alice Jeanne Fernandes 1240am Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery Holy Cross If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral (Month, Day, Year) Days Hours 116-50-5088 56 Director 1 □ M 2 X F 7/29/1956 RI Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 72 hours after death with the Maryland Director Silver Spring 1 Yes XX No MD Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 4404 Emden St. 20906 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Waxes 2 □ No 1982 Yes, Give Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 White 1 Yes 2 KNo Specify 3 Widowed 4 Divorced it yes, Give Year or Dates Completed 1986 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other traumatic event, <u>the Menay injury or other traumatic event</u>, <u>the Menay injury or other traumatic event</u>, Elementary/Secondary (0-12) College (1-4 or 5+) RN Health Care 1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Harold McGee Jeanne Koelsch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 712 Crisfield Drive Annapolis, MD 21401 Bob McGee Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Excremation 3 Removal from State 4 Donation 5 Other (Specify) 11/29/2012 Glen Burnie, MD Atlantic Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. Annapolis, MD 21401 12 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death days Immediate Cause (Final Cirrhosis of Liver Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed sician and burlal-trans cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burla Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death Physician/ 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 212 No Month Year n signed by the a ld be detached f 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ End Stage Liver Disease, Bipolar, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown Records, After this certificate has been significate has been significated and a should list. Completed Encephalopathy, Depression, Alcohol Abuse 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 1/2 1/20 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital To the Hospital or Attending Prysis within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral directorial directory. မှု 1XXInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 XXVatural 2 Accident 3 Suicide injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier EXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Silver Spring, MD 20902 Arun Anuradha 10301 Georgia Ave. 31. Date filed (Month, Day, Year) NOV 3 0 2012

DHMH 17 Rev 06-2011

State

Registrar

ack

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 4083 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ 15 AM Richard Allen Forsyth 24-2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury Wicomico Coastal Hospice at the 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) 218-30-3454 Director 1 X M 2 □ F 76 12/30/1935 Washington, DC Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 Tes 2 X No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21804 USA 6858 Lois Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black White etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates. 1 Never Married 2 X Married Completed by 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) National Security Agency Electronics Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edna E. Musgrove Page 1 and 2 should be Thomas Carlton Forsyth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6858 Lois Ave., Salisbury, MD 21804 19a. Informant's Name/Relationship (Type, Print) Doris J. Forsyth/Spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Salisbury Crematory 11/27/2012 Salisbury, MD 4 Donation 5 Other (Specify) Sign, ture of Funeral Service Licensee 22. Name and Address of Facility Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Dompsox CFSP 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MEN Physician/ disease or conditi-resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or injury To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 L 9 ☐ Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available • Hospital or Attending Physician: The law 24 hours after death.
• Funeral Director: After this certificate has autopsy prior to completion of cause of death? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence _ 2 ☑ No 2 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 1 V Natural 5 Pending ☐ Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 3 L 29b. Signature 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NOVEMBER 27, 2012 ELIZABETH LOUISE GILBERT SARAH Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days (Month, Day, Year) Director 218-50-3224 1 □ M 2 🖾 F 19 1940 72 MD permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumetic event, the Medical Examination 2000. 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 X Yes 2 □ No MT Frederick Brunswick 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 19 East F Street USA 21716 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces? Black White, etc. δ 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates Specify Specify: Black 3 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) mail clerk National Geographic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence Edward Lawson Daisy Aphelia Beard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Gilbert, Sr./husband 19 East F Street, Brunswick, MD 21716 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 Donation 5 Other (Specify) Resthaven Mem. Gar. 12/01/2012 | Frederick, MD 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Licensee 1100 N. Maple Ave., Brunswick, MD 21716 23a. Part 1. Enter the issence, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Line only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physicien: The lew requires that the death certificate be executed sician end burlal-trans Due to (or as a consequence of): resulting in death) Last ettending physician I for use es the burla Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day 5 Other (specify) Pregnant at time of death ed by the e g Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? After this certificate has been signed funeral director, page 2 should be de Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 1 ☐ Yes 21 ☐ No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No မှ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H64135 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Frederick Memorial,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene <u>40833</u> Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) November ^{Day}4, 2012 Physician/ Ronald Dale Guthrie 11:35 A.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick 12122 Woodsboro Pike Keymar 5. Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Country)
West Virginia Months Hours (Month, Day, Year) 215-34-5915 Director 75 1**₹** M 2 □ F Jan 7, 1937 Usual Residence of Decedent is than "netural", or items 23e or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Frederick Keymar 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12122 Woodsboro Pike 21757 USA be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No ۾ 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Giv Completed 3 Divorced 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other treumetic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 12 Owner/operator Floor covering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ William Guthrie Margaret Dunithan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Guthrie / wife 12122 Woodsboro Pike, Keymar, MD 21757 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rocky Hill Cemetery 11-30-2012 Woodsboro, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown PIke, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): signed by the attending physician end Id be detached for use as the burial-transit or Attending Physician: The law requires that the deeth certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown within 24 hours efter death.

To the Funeral Director: After this certificate has been sis completely filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 N 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending e Hospital or Attendi 124 hours efter death. e Funeral Director: A 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. The deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) MO51610 ill 26 112 CW MToen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7115 Guilford Dr., #202, Frederick, MD 21704 Tolino / 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 06-2011

State

Box 68760

Division of Vital Records,

Darks

32. P. gistrar's Signature

29 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 19, 2012 10:50 A M Denise M. Green Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery 01ney Montgomery General Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Min. Hours Director 085-46-3872 1 ☐ M 2 🖾 F Yrs April 23, 1955 New York Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 XYes 2 No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3210 Norbeck Road # 304 20906 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. ģ 1 Never Married 2 x Married Specify: Black 1 Yes 2 X No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Case Worker Private other traumatic event, Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) 2 should be file h and Mental H 7 is marked ot ည Clifford Edwards Tina Jenkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2072019a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau 13209 Eldorado Greenfields Drive Bowie, Maryland Rahsaan Edwards - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Pate 28. cemetery, crematory or other place) Nov. 1 🖺 Burial 2 🗌 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven 2012 Silver Spring, Md. 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Stewart Funeral Home, Inc. John T. Stewart 4001 Benning Road NE Washington, DC M00560 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Dwr Onset and Death Immediate Cause (Final Physician/ Right Ankle Fracture disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** 1 year Congestive Heart Failure Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) ed by the attending physician and detached for use as the burial-transit Atrial Fibrillation l year that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical 8 years Hypertension death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Ectopic pregnancy Month Year Dav 5 Other (specify) 1 Yes 2 Leg Unknown signed to Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 X No 3 Probably 4 Unknown Chronic Obstructive Pulmonary Disease Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 Yes 2 No Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 X Yes 2 🗌 No မ 1 Inpatient 2 X ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 🔀 No 11/11/12 10:00 AM Investigation Fell out of bed 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Silver Spring, Md 3210 Norbeck Rd. # 304 20906 4 Homicide determined

Box 68760 P.O. Records, Division of Vital To the Hospital or Attending Physician: s after death. I Director: After the within 24 hours after death

To the Funeral Director: A
completely filled in by the f

Baltimore, Maryland 21215-0036

Registrar

2JM

Medical

29a. Certifier

rom

Michelle German, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8241 Georgia Ave.

Home

🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

C04228

Ste. 102

29d. Date signed (Month, Day, Year)

November 27, 2012

Silver Spring, Md.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2012 40	380	3	4
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		registrar	Certificate of Death Reg. No.								
Physicia ledical Exami		1. Decedent's Name (First, Middle, La	Maris Gi	Day Year 2, 2012	3. Time of Death 0351 hrs						
		4a. Facility Name (if not institution, g Easton Memorial Hospita	give street and number)	4b.	City, Town, or Location of Easton		4c. County of Dea	th			
	=	·	Sex 7. Age (In yrs. I			er 24Hrs. 8. Date of Birtl	n(MM/DD/YYYY) 9. B	irtholace (State or			
Funeral Director			M 2 F		Months Days Hours			ign Mary land			
Au w	- [Usual Residence of Decedent 10a. State 10b. County	10c City	Town or Location			,	10d. Inside City Limits			
8	ŗo	MD talb	0+	East	on			1 Yes 2 No			
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shematic event, the Medical Examiner must be notified at once	Director	10e. Street and Number	gton St. Apt.		21601		g. Citizen of What Co $\mathcal{U} \mathcal{S} \mathcal{F}$	4			
Jeath with ritems 23	Funeral	11. Marital Status 1 Never Married 2 Marrie	12. Was Decedent Ever in U.	.S. 13. Was I	Decedent of Hispanic Orig , specify Cuban, Mexican		14. Race - Ame White, etc.	erican Indian, Black,			
after of II., o	by F	3 Widowed 4 Divorce	ed If Yes, Give Yeer	1 Y	es 2 No specify:		Specify: B/	ack			
lours :		15. Decedent's Education (Specify			Usual Occupation (Give to the following of the following to the following to the following to the following the fo		16b. Kind of Business	s/Industry			
o 72 h	Set	Elementary/Secondary (0-12)	College (1-4 or 5+)		_		,				
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	Completed	17. Father's Name (First, Middle, La	ot)	Nere	r Worker	d.	Non	e			
filed all Hyg	Bec			10	18.MOUTHER	ubya Da	alder Surfame)				
21215-0036 uld be filed within 7 Mental Hygiene, marked other than c event, the Medica		De May i S 19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing A	ddress (Street and Num	ber of Rural Route Num	oer, City or Town, Sta	te, Zip Code)			
nore, MD 2121 ges 1 and 2 should be fi nt of Health and Mental ft: If item 27 is marked other traumatic event,		Ambya Do		10125	Washing	ton St. Apr	4.C Easto	n, MD. 21601			
ore, MI ssland 2 s of Health au If item 27	=	20a. Method of Disposition	20b.	Place of Disposition	on (Name of cemetery,	Date	20c. Location - City of	or Town, State			
Baltimore, permit. Pages I an Department of Hes Important: If ite		1	ify: Removal from State	radise	Comsteru	12/15/12	TYUVPE.	UD.			
alti mit. partm ports	4 Donation 5 Other Specify: Parad Se Crimetery 12/15/12 Trayle 12. Signature of Funeral Service Licensee 22. Name and Address of cility Henry Funeral Home, P. A. Security 12/15/12 Trayle 13/15/12 Trayle 13/15/12 Trayle 14/15/12 Trayle 15/10 Washington St. Cambrid 15/10 Washington St. Cambrid 15/10 Washington St. Cambrid 15/10 Washington St.										
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/Medical xaminer		Immediate Cause (Final disease or condition resulting in death)	a Sudden Unexpla		th In Infan	су		Death			
			Due to (or as a consequence of	of):							
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	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	c. Due to (or as a consequence of					-			
executed an and al - transit		events resulting in death) Last	d								
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8760, tificate be ng physic as the bur	Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of preg				23d. Date of delive	•			
68 certific nding ise as		past 12 months?	1 Live birth 4 Pregnant at time of de	2 Fetal		c pregnancy	Month	Day Year			
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Division of Vital Records, tal or Attending Physician: The law requirers after death. *I Director: After this certificate has been sited in by the finneral director, page 2 should be a page 2.	The state of the s										
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Fineral Director: After this certificate has been signed by the attending physicic completely filled in by the funeral director, page 2 should be detached for use as the burit	Medical	29a. Certifier (Check only one) 2 Medical Examin	ician: To the best of my knowled	lge, death occurre and/or investigatio	d at the time, date and plan, in my opinion, death oc	ace, and due to the cause courred at the time, date a	e(s) and manner as stand and place, and due to	ated. the cause(s)			
To wii	Š	29b. Signature and title of certifier	and manner stated.	 	29c. License number		29d. Date signed (M	fonth, Day, Year)			
	ĺ	Lemat Drushail	l, ml		O.C.M.E.		December 3, 20	012			
		30. Name and address of person wh	io completed cause of death (Iten	n 23a)							
		Pamela E. Southall, MD			N. Baltimore Street	t, Baltimore, MD 21	223				
Si	State 31. Date filed (Month, Day Year) 37 (Registrar's Signature Registrar DEC 11 2012										
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 40836 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 26, 2012 Pietro Serafino Griva, Sr. November 1:12 ΡМ Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery Social Security Number 8. Date of Birth (Month, Day, Year, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours Director 218-38-9241 1 🖾 M 2 🗆 F 85 May 5, 1927 Italy Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location at 10d. Inside City Limits Director notified 28a-f MDP.G. 1 Yes 2 XNo University Park 10e. Street and Numbe 5 10f. Zip Code 10g. Citizen of What Country? must be by Funeral 23a 7001 40th Avenue 20782 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Armed Force ö 1 Never Married 2 X Married be filed within 72 hours after 2 X No Specify: White 1 ☐ Yes 2 No Specify. If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the General Superintendent Car Dealership Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, nd Mental ဂ္ Unknown Unknown and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Rose Marie Griva/Wife 7001 40th Avenue, University Park, MD 20782 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State . Page 1 Department of Important: If it any injury or o Dec. 1, 2<u>012</u> 1 Burial 2 Cremation 3 Removal from Ft. Lincoln Cemetery 4 □ Donation 5 ☒ Other (Specify) entombment Brentwood, MD 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1 Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Clostridium Difficile Infection disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner COPD exacerbation Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): physician Completed by Physician/Medical IF FEMALE detached for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) the 1 ☐ Yes ≥ L g ☐ Unknown a Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? be Anemia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 Yes 2 No Yes 2X No Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital Other: ျှ 1 Yes 2 X No 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury 1X Natural 5 Pending work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number,

Box 68760 P.O. Records, Division of Vital Completely filled in by the funeral director, To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After

Baltimore, Maryland 21215-0036

building, etc. (Specify)	City or ic	own, State)
Ga. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occur of the country one) 1 Certifying Physician: To the best of my knowledge, death occur of the country one) 2 Medical Examiner: On the basis of examination and/or investigation only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death	n, in my opinion, death occurred at the time, date	and place, and due to the cause(s) and manner stated.
b. Signature and title of certifier	29c. License number D68681	29d. Date signed (Month, Day, Year) Nov. 26, 2012
Name and address of person who completed cause of death (Item 23a) (Type, Print) Charu Maheshwary, MD 1500 Forest Gle	en Road, Silver Spring	MD 20910

State Registrar

Medical

29a. Certific (Chec only of 29b. Signatu

30. Name ar

NOV 2 9 2012

determined

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 40837 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Mildred Miller Gruver 26-2012 14 4 1 Medical Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death omic If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Numbe . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Months 79 District of 579-42-2420 Director 1 M 2 F 07/11/1933 Columbia in then "neturel", or iteme 23e or 28e-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Meryland Director 1 Yes 2 No Deal Island MD Somerset 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21821 23129 Edelen Webster Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Š 1 Never Married 2 Married Yes 2 No permit. Pege 1 and 2 should be filed within 72 hours efter Depertment of Health end Mental Hygiene. Importent: if tem 27 is marked other then "neturel", or eny injury or other treumetic event; if a Madical Entra eny injury or other treumetic event. laryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Education Teacher Be 18. Mother's Name (First, Middle, Maiden Surname)
Pauline Allen Miller 17. Father's Name (First, Middle, Last) ည George Miller 19a. Informant's Name/Relationship (Type, Print) Elizabeth Simmons 19b Mailing Address (Street and Number or Fural Route Number City or Jown State Zip Gede) 21821 Spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 12/01/2012 4 Donation 5 Other (Specify) Cemetery Adelphi, MD. G.W. Hinman Funeral Home 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11673 Somerset Ave., Princess Anne, 21853 M00295 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CHRONIC disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of, Exami out of the control of the certificate has been signed by the ettending physician and filled in by the funeral director, page 2 should be detached for use as the buriel-transit or Attending Physicien: The lew requires thet the deeth certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 ☐ Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 1 No Other: Certificate: To I 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence To Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours of To the Funerei C completely filled Medical 29a Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2180 0 up atterm 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1 Decedent's Name (First Middle | ast) 2. Date of Death Physician/ Wilma Juanita Garland 1.38 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Allegany WMHS Cumberland 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Director 233-34-5805 1 □ M 2X F 87 April 5,1925 WV show 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director ed other than "natural", or items 23a or 28a-f s event, the Medical Examiner must be notified WV Mineral Ft. Ashby 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 118 Country Villa Apts. 26719 US 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black White etc. be filed within 72 hours after of ental Hygiene. rked other than "natural", or 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White 3 XWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Nurse's 10 Aid Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F Department of Health and Menta Important: If item 27 is marked any injury or call. မ Olivia Golda Ansel Howard Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Parsons PO BOX 69, Springfield, WV 26763 Baltimore, 20a. Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 2012 9. 4 ☐ Donation 5 ☐ Other (Specify) Ashby Cemetery Dec. Ft. Ashby, WV Signature of Funeral Service Licensee 22. Name and Address of Facility Shaffer Funeral Home, 230 E. Main ST., Romney, WV 26757 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death Month Day Year 1 ☐ Yes 2 Legar 1 ☐ Yes 2 Legar 2 ☐ Unknown P.0. ģ Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by hypertension Records, 1 Yes 2 No 3 Probably 4 Unknown melliter 24b. Were autopsy findings available prior to completion of cause of dialetes has death? perform certificate Yes 2XXNo 1 Yes 2 No Division of Vital filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 I ER/Outpatient 3 4 Nursing Home 5 Residence 6 Other (Specify) hours after death. Ineral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 072514 12/5/12

Registrar

DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Kelly Lin , 12500 Willowhook Rd , Cumberland , MD , 21502

gistrar's Signature

	Amen	ıd	#25 per MD G942	386 Type of	r Print in TRT of Maryla	Black II	ndelible	e Ink	. Ensi	ure A	II Copie	s Are	Legi	ble.		
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	5		Decedent's Name (First, Middle	e, Last)							2. Date of De	ath		.,	3. Time of Death	
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3	Examin	er	4a. Facility Name (if not institution				4b. City, To									
المحاجب	F		1205 Jacob T 5. Social Security Number	ome Hwy		. last birthday)	Por If Under 1		epos If Under		8. Date of Bir	irth				
	Funeral Director		049-38-3364 Usual Residence of Decedent	1 X M 2 □ F		6 Yrs.		Days	Hours	Min.	11/29		5	Coun		
7	and show dat	tor	10a. State 10b. County		10c. C	City, Town or Lo	cation			-	-			1	0d. Inside City Limits	
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5	age 1 ent of nt: If it y or o	20a. Method of Disposition 1 Burial 2 Commentation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 124/12 R.T. Foard Funeral Home, P.A. Rising												na s	CIID MD	
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_			23a. Part Enter the disea e, or shoot or heart failure. List of Immediat Cause (Final			ath. Do not ente	er the mode	of dying	, such as	cardiac c	r respiratory ar	rest,			Approximate Interval Between Onset and Death	
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death certificate be	ng phi as th	Med	IF FEMALE:													
4	attending pl	ian/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1									2:	3d. Date	of delive	ery Dav Year	
, a	ned by the a detached f	Physician/Medica	1 Yes 2 No 9 Unknown	g Uni		r death 5	_ Other (spe	CIIY)								
† †	gned by		Part II. Other significant condition			esulting in the u	ınderlying ca	use give	en in Part I		23e. Did t	obacco us	e contrik	oute to th	e cause of death?	
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Phys	r this	<u>ن</u>	27. Manner of Death	28a. Date	Inpatient 2	ER/Outpatier 28b. Time of		c. Injury	4 ∐ Nu		me 5 Resi				urant	
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or Attending	25. Was case referred to medical examiner? 1											or Rural	Route Number,			
	ours af	29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.														
To the Hospital	n 24 hc	Medical	(Check 2 Medical E		asis of examinati	on and/or invest	tigation, in my	y opinior	n, death oc	curred at	the time, date a	and place, a	ind due t	to the cau	use(s) and manner stated.	
Ę	within Comp	~	29b. Signature and title of certifier)		, 3,			number	0 (_	29d. Date				
			► YUX	me			C	OC.	DO	142		12/	3/1	2		
	7		30. Name and address of person		•											
	Stat	Dr. Mona Parikh 510 Christiana Medical Ctr. Newark, DE 19702														
	Registra			U 2 20 12	house	J. 131.	All In	MIL	<u>ر</u>							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year 6:53 P M Walter H. 2012 Harper Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Thomas More Hyattsville Prince George's 8. Date of Birth
(Month, Day, Yea
Jan. 26, 9. Birthplace (State or Foreign Country)
Washington, DC Social Security Number . Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Days 1**X** M 2 □ F Director 578-36-6637 81 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f sho ner must be notified at Director X Yes 2 □ No Prince George's Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4411 Maple Road 20746 USA 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Examiner Black, White, etc. 1 Yes 2 □ No If Yes, Give Year or Dates. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Black 3 Widowed 4 Divorced Completed traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Postal 2yrs Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o ပ္ permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic. George Harper Gertrude Lee 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marsha Harper-Romero/Daughter 4411 Maple Road, Suitland, MD 20746 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Veterans Cemetery! Cheltenham, Maryland 22. Name and Address of Facility J.B. Jenkins Funeral Home, Inc. Signature of Funeral Service Licensee 7474 Landover Road, Hyattsville, MD 20785 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Atherosclerotic Cardiovascular Disease disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Hypertension Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Atrial Fibrillation certificate ha performed? 2 X No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) After this funeral of 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28d. Describe how injury occurred 28c. Injury at injury work? 1 ☐ Yes 2 ☐ No 1X Natural 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al completed filled in by the fu Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Menth. Day, Year) 2012 D0063681

State Registrar

DHMH 17 Rev 7/2009

GJM

Ajit Kurup

31. Date filed (Month, Day, Year) 2012

Hyattsville, MD 20783

1835 University Blvd. E. Ste. 208

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Azmera Amdie Hadgu 3:00 PM November 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 22 Sutton Court Upper Marlboro Prince George's Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 579-80-8275 1 🎛 M 2 🗆 F 62 January 23, 1950 Ethiopia Usual Residence of Deced show 10a. State 10b. Count at 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f st must be notified MD Prince George's Upper Marlboro 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? Funeral 22 Sutton Court 20774 USA items death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ※ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian r than "natural", or iter the Medical Examiner 1 Never Married 2 X Married Black, White, etc. þ within 72 hours after Maryland 21215-0036 1 Yes 2 X No Completed 3 Widowed 4 Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Guest Services Hotel Service 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, should be file and Mental H is marked o ပ Hadgu Negussie Bezunesh Amdie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 Muluemebet Kelelaw / Wife 22 Sutton Court, Upper Marlboro, MD 20774 Baltimore, other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date of 1 🛮 Burial 2 🗌 Cremation 3 🗆 Removal from State ö permit. Page Department Important: It any injury or 12/3/2012 4 Donation 5 Other (Specify) Fort Lincoln Cemetery Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on Interval Between Immediate Cause (Final GTAS Physician/ Onset and Death disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Segregation list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) requires that the death certificate be executed and that initiated events resulting in death) Last physician a Due to (or as a consequence of) Physician/Medical P.O. Box 68760 as the attending IF FEMALE: use yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy jo in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 1 Yes 2 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Records, Completed 2 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page perform certificate 1 Yes 2 No Yes 2 Division of Vital Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No ျပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending injury within 24 hours after death.

To the Funeral Director: A completely filled in by the f Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I only one 29b. Signature and tipe of 29d. Date signed (Month, Day, Year)

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State Registrar

31. Date filed (Month, Day, Year) DEC 0 3

30. Name and address of person

FULLOODS

our D 6005 to CUNTOD

who completed cause of death (Item 23a) (Type

AUDOUSE RD STE3 CHEVERLY, MD 20985

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month HANDY SHOWELL MADELINE 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Keninsuln REGIONAL Medical 5\$4/564/4 KICOMICO Centa 5. Social Security Number If Under 1 Year If Under 24 M Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min. (Month, Day, Year) 217-28-3753 **Director** 1 🗆 M 2 🗶 F 80 OCT 22, 1932 MARYLAND filed within 72 hours enter tal Hygiene. ed other than "natural", or items 23a or 28a-f show e event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits SELBYVILLE SUSSEX COUNTY DELAWARE 1 X Yes 2 No ۵ 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19975 **52 BETHANY ROAD** UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ρ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) AGRICULTURE LABORER 11TH (POULTRY PLANT) Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental | Is marked o မ HARRY SHOWELL MARY LAWS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Heelth P.O. BOX 143 WESTOVER, MARYLAND 21871 GLORIA L. PUGH 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 Depertment of Important: If it any injury or o Page 1 1 X Burial 2 Cremation 3 Removal from State ZOAR GOLDEN ACRES DEC 1, 2012 BISHOPVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fungral Service Licer 22. Name and Address of Facility MO 1361 WATSON FUNERAL HOME PO BOX 125 MILLSBORO, DE Part 1. Enter the disease, or corpolications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a, Part 1. Enter the disease Approximate Interval Between Onset and Death Hypoteurion Immediate Cause (Final disease or condition Physician Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami ending physiclan and use as the burial-transi Due to (or as a consequence of): the ettending physiclan Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No 5 Other (specify) Month Day 1 Yes 2 2 9 Unknown be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, cate has been sig Completed 1 🗌 Yes 2 No 3 Probably 4 🗵 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate Yes 2 12 No 1 Yes 2 No Hospital or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 2 X No မှ 1 🗷 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA After this 24 hours after death.
Funeral Director: After thi
stely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending Matural injury 1 Yes 2 No ☐ Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical within 24 hound to the second 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature, and title of certifier 29d. Date signed (Month, Day, Year) man

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

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Back

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALI

2012

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32. Régistrar's Signature

1 - For State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. Nd

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

40843

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at <u>once.</u>		21. Signature of Fu		<u> </u>	1220						t-Stauf					
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spita nours neral y filled	ical	29a. Certifier 1	Certifying	Physician: To the b	est of my knowl	ledge, death o	occurred a	t the time	e, date and	l place, a	nd due to the ca	ause(s) an	d manner as	stated		
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical		Medical E	xaminer: On the bas Nurse Practitioner	is of examination	n and/or invest	igation, in	my opinic	on, death o	ccurred a	t the time, date a	and place,	and due to th	e cause		er stated
To the confidence of the confi	_	29b. Signature and	title of certifier	1-1-			290	. License	number			29d. Date	e signed (Mo	nth, Da	y, Year)	
		1	Ul	has m	0		D0032518 12					12	2/3/12			
		30. Name and addr	ess of person	who completed caus		123a) (Type, P		171								
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Stat Registra		31. Date filed (Mont.		4 2012 32. R	gistrar's Signat	ture	on the	1								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Dav Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death P Social Security Number 8. Date of Birth Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 1 M 2 K Days Min 7/1/1941 194-32-3002 71 Director Pennsylvania Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Marvland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 3321 Old Point Rd. 21037 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. 1 Never Married 2 X Married Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Social Worker Non Profit Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Blanche Eliot John R. Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3321 Old Point Rd., Edgewater, MD 21037 Bruce A. Hechler/ Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗆 Burial 2 🏌 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 11/30/12 Edgewater, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Carcinomatosis from a low-grade Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ Pregnant at time of death signed by the a Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 1 Yes 2 1No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Other: 2 W No မ ER/Outpatient 3 DOA 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No □ Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 29b. Signature and title of certifier 307 8

Registrar
DHMH 17 Rev 7/2009

Registrar's Signatu

GM

212-02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 40845 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Bonnie Mae Jones Medical Dec 2012 9.282 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 100 McNamee Ln. Apt. 106 Rising Sun Cecil . Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 220-50-3127 Director 85 1 - M 2 X F 2/24/1927 VA 28a-f show 10a. State 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Cecil 1X Yes 2 □ No Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 100 McNamee Ln. Apt. 106 21911 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. "natural", or \$ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 vithin 72 hours after 1 Yes 2 No Specify 3 → Widowed 4 □ Divorced Completed Specify: White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Department of Health and Mental Hy, Important: If item 27 is marker any injury or other the once Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Thomas Lee Johnson Margaret Poston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bronson Jones/ Son 80 Ridgewood Dr. Hanover, PA 17331 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place Rosebank Cemetery 4 Donation 5 Other (Specify) 12/6/2012 Rising Sun, MD Signatur of Funeral Service Lic R.T. Foard Funeral Home, P.A. 111 S. Queen St. Rising Sun, sus Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Obstructor Pulmonary disease or condition resulting in death) hron 3 years ▲ Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Litter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?
1 ☐ Yes 2 No Month Year Pregnant at time of death Day 9 Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Pirrensod 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Hospital 1 Yes 2 No Other: ည 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 🗌 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 Natural 5 Pending work 1 Yes 2 No Accident Investigation 6 Could not be Suicide 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the P 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

10

DHMH 17 Rev 06-2011

State Registrar and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Joseph Weidner, MD

31. Date filed (Month, Day, Year)

00044373

101 Colonial Way Ste. A Rising SUn, MD 21911

12/63

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 40846 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Paul Ricardo Johnson M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Holy Cross Hospital Silver Spring Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 12-06-1953 223-82-9927 Virginia Director 1X M 2 F 58 Usual Residence of Decedent 2 should be filed within 72 hours efter death with the Maryland the end Mental Hygiene.
27 is marked other then "neturel", or items 23e or 28e-f shov traumetic event, the Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring 1√2 Yes 2 ☐ No MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14151 Castle Blvd. #104 20904 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 2 □ No 1972-1 Never Married 2 Married by 1X Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black Completed 3 ☑ Widowed 4 ☐ Divorced 1976 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Dispatcher Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Mae Viola Johnson Lloyd permit. Pege 1 and 2 should be Depertment of Health end Men Importent: If item 27 is marke eny Injury or other traumetic ency. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14151 Castle Blvd. #104 Silver Spring, MD 20904 Virginia Lloyd/Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State MD Veterans Cemetery 12-5-2012 Cheltenham, MD 4 Donation 5 Other (Specify) 22. Name and Address of FacilityRonald Taylor II FH Signature of Funeral Service Lice 10583 Middleport Ln. White Plains, MD 20695 23a. Part 1. Enter the disease, or complications at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition a Small Bowel Obstruction Medical resulting in death) Due to (or as a consequence of) Examiner b. Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospitel or Attending Physicien: The lew requires that the death certificate be executed within 24 hours after death.
To the Funerel Director After this certificate here has been completely filled in the contract of Cause (Disease or injury that initiated events resulting in death) Last Dehydration Due to (or as a consequence of): Physician/Medical d <u>Metastatic Disease</u> IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
2 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? g | Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autoosy Yes 2 X No 1 ☐ Yes 2 ☐XNo 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🔀 No |은 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending X Natural injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 11/26/2012 uar D60826 if i Jim 30. Name and address of person who completed cause of death (Ite 23a) (Type, Print) Kshama Garq 1500 Forest Glen Rd Silver Spring, MD 20910

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day

32/Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 7145a M Bertha Naomi Johnson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Joseph Richey Hospice Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days (Month, Day, Year) Hours 77 Director 358-26-4360 1 M 2 AF 12/25/1934 Alabama iral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland Director 1 X Yes 2 No Washington, DC 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 1311 Delaware Avenue S.W. 20024 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black Specify. and Mental Hygiene. is marked other than "natural", 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Treasury Clerk U.S. Treasury Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Page 1 and 2 should be Wil Long Bertha Dixon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a t: If item 27 is or other tra Myra Johnson -Lane / Daughter 479 State Route 32 Wallkill, New York 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Durial 2 Cremation 3 Removal from State 12/01/2012 Clinton, Maryland Resurrection Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Rd. Oxon Hill, Maryland 20745 21. Signature of Funeral Service Lic 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Exami attending physician and I for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year ate has been signed by the a page 2 should be detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗗 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific: completely filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 100 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Matural 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: the Hospital or Attending 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 — Gertifying Nurse Prantitioneri Tu the best of my knowledge, death constitud at the time, daw and plane, and due to the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Tom 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Widen AV Back Mp 3/201 LEWFUTF BEAUN 32. Registrar's Servature

State Registrar

Johnson expired @745 am

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State State Certificate of Death Reg. No. 2 0 2 4 0 8 4 8																
			Registrar	1 ()		tificate of L	Death	I	Reg. No.	12	40848					
	Physicia	n/	1. Decedent's Name (First, Middle	,					2. Date of Dea	er 22,	o Year o	3. Time of Death 8:49 A M				
	Medic		4a. Facility Name (if not institution	tephen Ji			4h City Town or	Location of Death	Novemb	4c. County		0:49 A W				
	Examin	er	1702 Golf Cours		ibei)			tchellvil	1e	1		orge's				
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h	9. Birthp	lace (State or Foreign				
	Director		341-48-4221	1 🍱 M 2 🗆 F	59	Yrs.	Months Days	Hours Min.	(Month, Day	, Year)	Count M-i	ssouri				
	t ow	_	Usual Residence of Decedent 10a. State 10b. County			y, Town or Loc	cation		Aug. /	, 1755	<u> </u>	Od. Inside City Limits				
	arylan a-fsh fied a	cto		Coommol		,, 10,111 0. 201		Mitche:	11wi11a			1 🙀 Yes 2 □ No				
	he Ma or 28,	Dir.	Maryland Princ 10e. Street and Number	e George	5		10f. Zip Code	FILCTIE		10g. Citizen of	What Coun					
	23a st be	eral	1702 Colf Cour	o Drivo				20721		Unit	ed St	ates				
	tems er mu	Maryland Prince George's Mitchellville Top														
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212	within giene. er tha er the		Elementary/Secondary (0-12)	ernme	ent											
p	be fled within 72 hours after death with the Maryland and Hygiene 14 hours 28a or 28a-f sho ked other than "natural", or items 23a or 28a-f sho ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	o Be	17. Father's Name (First, Middle, L	e)												
ya	should be filed within 73 and Mental Hygiene. is marked other than aumatic event, the Me	ပ	Chance Ollie						se Emma							
Mai	2 shoi h and 7 is n traun	9	19a. Informant's Name/Relations					and Number or Rura								
e)	and and thealthealthealthealthealthealthealtheal		Wendy Maria Jin	merson - :	20b. P	lace of Dispo	sition (Name of			20c. Location						
Baltimore, Maryland 21215-0036	age 1 ent of nt: If ii y or c		1 🙀 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State C	emetery, cren	natory or other plac	ery 2012	^D 30 t h		•	Maryland				
慧	mit. P bartme sortar ' injur		21. Signature of Funeral Service I		Į FL.			ss of Facility St								
m	permit. Page 1 and 2 should be filed Department of Health and Memtal Hy Important: If item 27 is marked out any injury or other traumatic even once.	hington	-	20019												
			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that only one cause on ea	caused the death	h. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arr	rest,		Approximate Interval Between				
P	hynesay	1	Immediate Cause (Final disease or condition		lioblast	toma					1	Onset and Death 18 months				
	Medical Examiner		resulting in death) Due to (or as a consequence of):													
		ier	Sequentially list conditions,	b. — Due to	for as a consequ	uence of):					-					
	rted 3 ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury													
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09	ate be executed bhysician and the burial-transit	dical		d												
687	ding p	/Me	IF FEMALE:	23c If yes out	come of pregna	ncv										
Box (eath certificat attending ph for use as th	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 🔲 Live	Birth 2 Feta	al death 3	Ectopic pregnance Other (specify)	су			ate of delive onth	ery Day Year				
ă	es that the des signed by the a I be detached i	nysi	1 Yes 2 No 9 Unknown	9 🗌 Unki												
P.0	that t ned by e deta	by Pl	Part II. Other significant condition	ons contributing to d	eath but not res	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	obacco use con	tribute to th	e cause of death?				
g,	requires been sig should b	ed k							1 🗆	Yes 2 🔀 No	3 Prob	pably 4 🗆 Unknown				
Records,	aw rec as bee 2 sho	Completed							24a. Was autop		prior to cor	osy findings available inpletion of cause of				
Re	Physician: The law this certificate has ral director, page 2	Son								rmed?	death?	2 🗆 No				
ta	cran: ertific ector,	Be	25. Was case referred to medical examiner?	Hospital:			26. Pl	ace of Death (Chec	k only one)							
	Physi this c	٠ <u>.</u>	1 Yes 2 KNo 27. Manner of Death	1	Inpatient 2 -	ER/Outpatier 28b. Time of	nt 3 🗆 DOA	4 U Nursing Ho	ome 5 XResion 28d. Describe h)				
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Division of Vital	Atten	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28c. Injury at work? 1 Yes 2 No 28d. Describe how injury occurred										Route Number,				
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,	To the hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	29a. Certifier (Check only one) 1														
	thin 2	ĭ	only one) 3 Certifying 29b. Signature and title of certifie		,		29c. License			he cause(s) and 29d. Date signe						
	F > F %		> chatthia	s Mid	M	4.0	1	D0066034		Novemb						
	205.11		30. Name and address of person	who completed caus	se of death (Item	23a) (Type, F	Print)					·				
	C)&I		Mattlias Holdh					altimore,	Md. 2	1287						
á	Stat	te	31. Date filed (Month, Day, Year)	12 Senes	legistrar's Signat	ture										
	Registra	al .	MOLAGE	7-1-1												

12-08721 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Sharod D. James State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death **Medical Examiner** November 17, 2012 Sharod D. James 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Prince George's Hospital Center Cheverly Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Min Davs Hours Director 1 XM 577-06-3634 Aug. 19, 1981 Countr 31 Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits , or items 23a or 28a-f show r must be notified at once. 1 XYes 2 No permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once MD PG Capitol Heights Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1905 Brooks Drive #T2 20743 United States Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14, Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married White, etc. 2X No Yes 3 Widowed 4 Divorced If Yes, Give Year Yes 2 No specify. Specify: Black Š 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 Student 2 Shad/UDC 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Harold James Linda Mason 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 905 Brooks Drive #T2 Linda Baxter/Mother 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c. Location - City or Town, State crematory or other place) 11/24/12 1 X Burial 2 Cremation 3 Removal from State Clinton, 4 Donation 5 Other Specify. Resurrection Cemetery MD 22. Name and Address of Facility Hodges Signature of Funeral Service License & Edwards F.H. 3910 Silver Hill Rd., Suitland, MD. 20746 rt I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval lure. List only one cause on each line /Medical a Multiple Gunshot Wounds of the Head xaminer Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and - transit Physician/Medical UNPENDED attending physician or use as the burial AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day past 12 months? Pregnant at time of death 5 Other (Specify) detached for 1 Yes 2 No 9 Unknown Unknown signed by t. I be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed page 2 should 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has l performed? death? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other₄ Nursing Home 5 Residence 6 Other this ٩ 1 🗸 Yes After 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Nov 16, 2012 Subject shot __ Natural 2352 hrs death. Pending Yes 2 🗸 No the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City

0038 hrs

Between Onset and

Death

Year

2 No

or Town, State) 5601 Martin Luther King Jr Highway, Seat Pleasant, MD

November 17, 2012

29d. Date signed (Month, Day, Year)

Division of Vital Records, P.O. Box 68760, To the Funeral Director: filled in by 24 hours after

3

Medical

State Registrar Suicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

4 Momicide 29a Certifier 1

DHMH 17 Rev 1/2001 OCME 2006

0 A

Donna M. Vincenti, MD

Could not be

determined

OCME

Name and address of person who completed cause of death (Item 23a)

(Specify) Parking Lot

Assistant Medical Examiner

3. Registrar's Signature

and manner stated

ORIGINAL

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Wedlcal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar I. Decedent's Name (First, Middle, Last) 2. Date of Death November 15, 2012 Physician/ Jagdhale Suresh Tataba 8:20am м Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 217-87-6114 Days Hours Director 1 ÅM 2 □ F 58 June 22, 1954 India should be filed within 72 hours are and Mental Hygiene.
If is marked other than "natural", or items 23a or 28a-f show are are as a marked other than "natural", or items 23a or 28a-f show are are as a marked other than "natural case," and the routified at a marked as a m 10a. State 10b Count 10c. City, Town or Location 10d. Inside City Limits Directo MD 1 Yes 2 TNo Montgomery Silver Spring 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 214 Crestmore Circle 20901 India Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes ②XIX No
If Yes, Give Black, White, etc 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 Specify: Asian Indian 1 ☐ Yes 2 A No Specify: 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Publishing Graphic Artist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Tataba Jagdhale Ellen Rakshe 1 and 2 should be Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clara Suresh Jagdhale/Wife 214 Crestmore Circle, Silver Spring, MD 20901 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Nov. 23, permit. Page 1 a Department of H Importent: If Ite eny Injury or ot 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Gate of Heaven Cemeterly Silver Spring, MD 2012 21. Signature of Funers Andre Licensee Francis Address Cormins Funeral Home Inc. Lateo Trekord L 500 University Blvd. W. Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Acute Myocardial Infarction weeks Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burial attending physiclan Physician/Medical Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) Day Year signed by the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ cate has been signed page 2 should be 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 autopsy performed 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 🖾 No 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 K Natural 5 Pending М 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

State

D20062

8201 16th Street, #121, Silver Spring, MD 20910

Nov. 16, 2012

P. Kannaskat

Tony Kannarkat, MD

19

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

62. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40851 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 11/23/2012 Robert John Klein, Sr. 8:45 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospice Dove House Westminster Carroll 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Davs Hours (Month, Day, Year) Country) Director 275-32-6769 1**X** M 2 □ F 76 09/24/1936 Usual Residence of Decedent is then "neturel", or Items 23a or 28e-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours efter death with the Maryland Director MD Carroll 1 Yes 2X No Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21074 USA 4418 Black Rock Road, Apt. 2 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ai Hygiene. I other then " Elementary/Secondary (0-12) College (1-4 or 5+) Sheetmetal Worker Nelson and Barnes permit. Pege 1 end 2 should be flied w Department of Health end Mentai Hygi Importent: If Item 27 is merked othe eny Injury or other treumetic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Robert Klein Cecelia Anne Oprin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4681 Catalina Drive, Hampstead, MD 21074 Lori Swank/daughter Baltimore, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) Greenlawn Mem. Park 11/27/2012 Akron, OH 22. Name and Address Praditts Funeral Home and Chapel, PA ture of Funeral Service Licensee 21157 412 Washington Road, Westminster, MD Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any leading to immediate cause. Enter Underlying Due to for as a consiquence of 24 hours after death. From this certificate has been signed by the attending physician end ether in the funeral Director. After this certificate has been signed by the funeral director, page 2 should be deteched for use as the burial-transit Hospitel or Attending Physicien: The lew requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23h Was decedent pregnant in the past 12 months?

1 Yes 2 No Ectopic pregnancy Month 5 Other (specify) Pregnant at time of death g 🗌 Unknown g Unknown Part II. Other signi tions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🖪 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hospi within 24 hou To the Funer completely fil 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only on 29c. License number 29d. Date signed (Month, Day, Year) pleted cause of death (Item 23a) (Type Print) 32. Registrar's Signature State 2012 MAIKE Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 7:57 p M e GAN 11 Medical 4c. County of Death
Anne Arundel 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harwood Mandrin Inpatient Care Center 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 1^{Year)} 1971 **Funeral** Month, Day, Ye June 24, Days Hours 219-15-9219 Washington, DC 41 Director 1 🗌 M 2 🔀 F 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State Director Annapolis Anne Arundel Maryland 1 Yes 2XXNo 10g. Citizen of What Country? U.S.A. 10f. Zip Code 10e. Street and Number 3223 Blackwalnut Drive 21403 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 KMo Black, White, etc. 1 Never Married 2 Married <u>ک</u> Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or White 1 ☐ Yes 2XXNo Specify. If Yes Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Architectural Draftsman Architecture Be 18. Mother's Name (First, Middle, Maiden Surname)
Mary J. Lawrence 17. Father's Name (First, Middle, Last) Paul J. Clarke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21403 Annapolis, Maryland 3223 Blackwalnut Drive William Brant Kolb, III/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Mary's Cemetery 12/3/2012 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State ō Department Important: It any injury or once. Annapolis, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Six alum uneral er ce Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final DREAST Physician/ ase or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underning Cause (Disease or injury Due to (or as a consequence of) this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 2 No Yes 2 No 1 Yes 1 OSPICE 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 K Other (Spec 2 1 No ၉ 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA House filled in by the funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 24 hours after death. Funeral Director: After 1º Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou To the Funer completely fil 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29b. Signature and title of certifier n chae

9

Registrar

DHMH 17 Rev 06-2011

State

Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) NOV 3 0

NOV

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

	For State	State of Man	yland / Dep	artment of	Health and I	Mental Hy	/aiene	gibic.	
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					r Location of Death		4c. Count	y of Death	
Funeral	5. Social Security Number	or Healthcare	yrs. last birthday)	Risin If Under 1 Year	g Sun I If Under 24 Hrs.		Cec		
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at at	Usual Residence of Deceder 10a. State 10b. Cou					3/18/	1919		PA
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rylar rylar uld be f I Menta narked natic ev	Nicholas De	Fonsey			Amelia)	
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exami To Be Completed by	19a. Informant's Name/Relation		19b. Mailing	Address (Street a	nd Number or Rural	Route Number	City or Town St	tato Zin Co	dol
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Baltimore, M permit. Page 1 and 2 si Department of Health a Important: If item 27 is any injury or other tra once.	1 X Burial 2 Cremation	n 3 ☐ Removal from State	cemetery, crema	tory or other place) D	ate	20c. Location -	City or Tow	n, State
altin	4 ☐ Donation 5 ☐ Other 21. Signature of Funeral Service	(Specify)	esurrec	tion Ce	m. 12/6	5/12	Harris	oura.	Dλ
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ital I	. Was case referred to medical					performe	dea No 1	th? Yes 2	No
Physic this ce all dire	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	FR/Outnationt 3	Othor	of Death (Check on				
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Attend death death y the f	2 Accident Investig	ation	1		2 🗆 No		ingary occurred		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2 0 | 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year ZD/2 November Louise Lyons 7:20 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Southern Maryland Hospital Clinton If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Director 241-36-9588 1 🗆 M 2 🛛 F Jan. 1, 1925 North Carolina 2 should be filed within 72 hours after death with the Maryland th and Mantal Hyglene.
27 is marked other than "netural", or Iteme 23e or 28e-f ehor traumatic event, the Madical Examiner in ust be invitted at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Washington DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 200 34th Street SE 20019 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ۾ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 **Black** 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Private 6th Housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ೭ Guy Lyons Annie Hinton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Venessia Lyons - Daughter 1617 T. Street SE #3 Washington, DC 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of I Importent: If its any injury or of 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Dec. 4 ☐ Donation 5 ☐ Other (Specify) Lee's Crematory 2012 Clinton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. John T. Stewartz 4001 Benning Road NE Washington, DC 20019 M00560 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Collapse Physician/ Cardiopulmonary disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner hours Sequentially list conditions, if any, leading to immediate cause Entur Underlying Cause (Disease or injury Due to (or as a consequence of): Exami Bacteremio that initiated events resulting in death) Last Due to (or as a consequence of): physician ar is the burial-t Imunocompromised State Physician/Medical Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 inonths?

1 Yes 2 No Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Malnutrites 23e. Did tobacco use contribute to the cause of death? ۾ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Confinement Status 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Rhermotoid 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartific completely filled in by the funeral director, 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 DNo မ 1 Xinpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending Division 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 4 Homicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. □ Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

□ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 75th 2012 D52865 Jn 30. Name and address of purson who completed cause of death (Item 23a) (Type, Print)

State Registrar \$2. Registrar's Signature

12150 Annapolis Rd Ste 200

Glenn Dole

20769

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/ Nov. Aden C. Langford 24, 7:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's County Hospital Leonardtown Saint Marys Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** , Year 1925 Months Days Hours sept 10, 230-20-8592 87 Maryland 1 🛛 M 2 🗆 F **Director** ms 23a or 28a-f show must be notified at 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County Director Saint Marys MD Leonardtown 1 ☐ Yes 2 🔀 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 39587 Potomac Ave. 20650 USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces? Black White, etc. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than College (1-4 or 5+) Elementary/Secondary (0-12) and Mental Hygiene. Electrical Engineer U.S. Govt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John N. Langford Ruth Cheney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shou Department of Health and Important: If item 27 is m Constance Langford - Wife Potomac Ave. Leonardtown, MD 20650 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXBuriai 2 ☐ Cremation 3 ☐ Removal from State injury or Mt Comfort Cemetery 11/30/2012 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 21. Signatur of uneral Service Licensee 22. Name and Address of Facility Everly-Wheatley 1500 W. Braddock Rd Alexandria VA mo145 1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ onc disease or condition now Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to jor as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Live Birtin 2 - 1000. Pregnant at time of death in the past 12 months? Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an LAng-Ford, autopsy performed To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director. After this certificate homes of the funeral Director, page completely filled in by the funeral director, page 2 No 1 Tes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Tes 2 No Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? Accident 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, initing opinion, detail occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 25 SC Gaby M.D. D54346 SM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHANDRA SAJJA B-24035 THREE NOTCH ROAD, HOLLYWOOD MD 20636 Registrar's Sign State Registrar

DHMH 17 Rev 06-2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State State Registrar amend #28d per MD FCHD LE Certificate of Death 11/29/12 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 24 201212 17 Physician/ Murran hristopher November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hopkins Hospital Baltimore The Johns 8. Date of Birth (Month, Day, Year) 03-19-2011 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Country) Maryland 212-91-0516 Director 1 X M 2 □ F Usual Residence of Deceden in than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2 X No Frederick Monrovia 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 4703 Green Valley Road 21770 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14 Race - American Indian 11. Marital Status Black, White, etc. Š 1 X Never Married 2 Married within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: If Yes, Give Year or Dates Specify: White 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Pege 1 and 2 should be filed within 72 Department of Health end Mental Hygiene. Important: If item 27 is marked other than 'any Injury or other traumatic event, <u>the Me</u> Elementary/Secondary (0-12) College (1-4 or 5+) None None Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Johnnie Wayne Murrah Sheila Dawn Metz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sheila Metz/ mother 4703 Green Valley Rd., Monrovia, MD 21770 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Olivet Cemetery 11-29-2012 Frederick, MD 22. Name and Address of FacilityStauffer Funeral Homes, P.A. Signature of Funeral Service Licensee elu 8 E. Ridgeville Blvd., Mt. Airy, MD 21771 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Hypoxic Ischemic Encephalopathi Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Drowning Sequentially list conditions, if any, reading to itimirediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence physician and s the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificete be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the bu CERTIFICATION APP Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No

9 Unknown Month Day Year 4 Pregnant 9 Unknown 5 Other (specify) Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ္ 1 N Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: ☐ Natural 5 Pending 1810 rell 1 ☐ Yes 2 Ø No HOT 22/2012 tube Accident Investigation
6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
4703 GREN VAILEY ZOOL 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Green Valler Road MONTOV, a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) que str Res-000 24 2012 November 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21287 Hunt 1800 orleans St Balto mo 31. Date filed (Month, Day, Year) State NOV 2 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 40858 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 11 Elizabeth Melendez 2012 1750 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges <u>Prince Georges Hospital</u> Center Hyattsville If Unde g. Birthplace (State or Foreign Country) England United Kingdom . Age (In yrs. last birthday 8. Date of Birth **Funeral** If Under 24 Hrs 1 □ M 2 🌣 F Months Days Hours Min Director Yrs 211-50-7546 63 01/16/1949 Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10a. State 10b. County be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🔀 Yes 2 🗆 No MD Prince Georges New Carrollton 10e, Street and Number 10g. Citizen of What Country? England Funeral 20784 8502 86th Court British United Kingdom 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces?

1 Yes 2 No 14. Race - American Indian, Examiner Black, White, etc. 1 Never Married 2 Married ò þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify. "natural", Completed 3 Divorced 4 Divorced Specify: Caucasian the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Bookbinder</u> Printing/Bookbinding other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ permit. Page 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any injury or core. Thomas Spedding Elizabeth Anne Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8502 86th Court New Carrollton, MD 20784 <u>Julio Melendez - Spouse</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery: 11/28/2012 Brentwood, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Ft. Lincoln Funeral Home Bladensburg Road Brentwood, MD 23a. Part 1. Efter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year been signed by the should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 🗌 Yes page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? certificate 2 🗀 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) 8 examiner^e 1 \(\text{Yes} Other: |은 1 Impatient ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Director: After this din by the funeral din Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 \square Yes 2 🗌 No Accident Investigation Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basks of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

16,24

State Registrar

(Check

only one

3

30. Name and address of person who

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Certifying Nurse Practions

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DHMH 17 Rev 7/2009

Hos

cause of death (Item 23a) (Type, Print)

3001

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 27, 201 Physician/ November, 0120 am William Morrison Thomas Jr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death DORCHESTER GENERAL HOSPITAL DORCHESTER CAMBRIDGE Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
June 7, 1945 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 1 🖳 M 2 🗆 F 138-36-1229 Pennsylvania 67 Director Usual Residence of Decedent 10a. State 10b. County any injury or other traumatic event, the Medical Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits Director MD Dorchester or items 23a or 28a-f Vienna 1 🗌 Yes 2 👿 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4039 Steele Neck Road 21869 **USA** 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 🕱 Married Completed by be filed within 72 hours after 1 X Yes If Yes, Give white 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Year or Dates. 1965-67 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) apartment building maintenance supervisor Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Thomas William Morrison Mary Montz should t 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Page 1 and 2 Margaret Morrison wife 4039 Steele Neck Road, Vienna, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/1/12 Crematory of Delmarva Delmar, DE 22. Name and Address of Facility Thomas Funeral Home P.A. Signature of Funeral Service Licenses 1.4 700 Locust St Cambridge, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Ta disease or condition (t Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year sate has been signed by the a page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but my tresulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Ses 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? within 24 hours after deam.

To the Funeral Director, After this certificate homeleted filled in by the funeral director, page Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ 1 Yes Phopatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatore and title of 29d. Date signed (Month, Day, Year)

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who completed cause of death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fur				IMC	· 0†							neral			nc.
permi Depar Impor any ir		array	Late.	ou Day	and C	053	o					_		hingto			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 16, 2012 12:15 A M **MILLER** Frances Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Chevy Chase Montgomery Manor Care Chevy Chase If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Mar. 31, Year) 947 Social Security Number 6. Sex Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Hours 1 □ M 2 🏋 F Washington, DC **Director** 65 215-54-5502 Usual Residence of Decedent or 28a-f show e notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Rockville Montgomery Maryland 1 Yes 2 No 10g. Citizen of What Country? "natural", or items 23a o 20852 Funeral 6020 California Circle #203 United States death 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 📉 No þ 1 V Never Married 2 Married 1 Yes be filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Divorced white Completed Year or Dates f Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical I Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government <u>Secretar</u>ial Page 1 and 2 should be filed with ment of Health and Mental Hygier ant: If item 27 is marked other: Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Laurette Whitten Archie Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21321 Ridgecroft Dr., Brookeville, MD 20833 Bess Teller, Friend Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 XBurial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place King David Memorial Garden 11/18/12 Falls Church, VA of Figureral Servic Licensee Tonchamskys Hearew Funeral Home 20012 254 Carroll St., NW, Washington, DC 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, wheart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph, i i n Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Bronchiectasis Sequentially list conditions, if any, leading to immediate cause. Linter underlying Examir Cause (Disease or iinjury that initiated events resulting in death) Last Chronic Obstructive Pulmonary Disease physician and sthe burial-trans Due to (or as a consequence of) Physician/Medical that the death certificate be ding IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy
5 Other (specify) detached for Month Dav Year Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 X No 2 \square No Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work?
1 Yes Natural 5 Pending 2 🗌 No Accident Investigation 6 Could not be

P.O. Box 68760 Division of Vital Records, To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate сотрleted filled in by the funeral director,

Suicide

Date filed (Month, Day, Year)

NOV 19 2012

determined

4 Homicide

29a, Certifier (Check

Certifying Nurse Practioner: To the best of my knowledge, death occ urred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and tire of certif 29d. Date signed (Month, Day, Year) 2012 D 35579 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8218 Wisconsin Ave., #305, Bethesda, MD 20814 Miller.

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State

Medical

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State
Registrar AMEND#5+19aper INF, 11/28/12; BMW, McCo Certificate of Death edent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 6 Medical Facility Name (if not institution, give street and number, Examiner Town or Location of Deatl 4c. County of Death mure Social Security Number 2.20 – 40 – 6.895 If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 8 Date of Birth Days (Month, Day, Year) Director 1 X M 2 F 69 1943 Washington, DC Feb. 17, 28e-f show 10a, State 10b. County 10c. City, Town or Location 27 is marked other then "naturel", or Items 23a or 28e-f sho treumatic event, the Medical Examinar must be notified at within 72 hours efter death with the Maryland Director MD Queen Anne's Chester 1 ☐ Yes 2XXX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 401 Bodys Neck Road 21619 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married ☐ Yes 2 🖾 No Baltimore, Maryland 21215-0036 Specify.White 1 ☐ Yes 2 ☑ No Specify: If Yes, Give 3 🗌 Widowed 4 🗌 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Pege 1 end 2 should be filed within 72 ment of Health and Mental Hygiene. ent: If item 27 is marked other then ' Elementary/Secondary (0-12) College (1-4 or 5+) Owner Deli Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frank James Marchone Suzanne Georgette Blaevoet 19a. Informant's Name/Relationship (Type, Print)
Sandy Schiavelo Marchone/Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandy 401 Bodys Neck Road, Chester, MD 21619 Sandra Schiavello Marchone Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Importent: If ite any Injury or ot Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Johns Cemetery Silver Spring, 21. Signature of Funeral Service Licenses Francis Adress Cornins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Inter the disease, or complications that saidsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Acu myeloblastic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Myelodysplasio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): ettending physician and for use es the burial-transit Cause (Disease or injury that initiated events death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ To the Hospital or Attending Physicien: The law requires that the death within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the etter Competely filled in by the funeral director, page 2 should be detached for the Competent of the content of the c in the past 12 months? Day Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No Yes 1 Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No မ 1 N Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident М 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State, Medical 29a. Certifie 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier RES - 600 November 2012 30. Name and address of person who completed caus death (Item 28a) (Type, Print) SEAN TACKETT 31. Date filed (Month, Day, Year) State NOV 19 2012 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** 0653 AM^M Charles L. Muir 2012 Nov. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13693 Allen Road Somerset <u>Princess Anne</u> 5. Social Security Number 7. Age (In yrs. last birthday, Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days 1☐M 2□F Hours **Director** Dec. 19, 1936 220-32-1867 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐ No Director Marvland Somerset Princess Anne 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 23a or pe 13693 Allen Road r than "natural", or items 23s the Medical Examiner must 21853 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No à Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and 2 should be filed withi ealth and Mental Hygiene. n 27 Is marked other than County Treasurer County Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leland S. Muir 2 Ruth Frances Pusey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If Item 27 Is any injury or other trau Dolores Muir Wife 13693 Allen Road, Princess Anne, Md. 21853 Pages 1 a 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State St Andrews Cemetery 11-25-2012 Princess Anne, Md. 4 ☐ Donation 5 ☐ Other (Specify) Hinman Funeral Home PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M00295 11673 Somerset Ave., Princess Anne, Md. 21853 7, art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Intriediate Cause (Final disease or condition resulting in death) ASCV **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed Due to (or as a consequence of) burial-P.O. Box 68760, physician Physician/Medical attending properties of the second se IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown by signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 No 1 Tyes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has , page 2 autopsy performed? 1□ Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 After this funeral d 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Hospital or Attending 1 Natural 2 Accident 5 Pending Injury the Funeral Director: Af investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 029105 Walleron M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Christjon Huddleston MD. 103 Milford Street, Salisbury, Md. 21804 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 27 Registrar

			For State	State of Mary	and / Depa	artme		ealth and I	Mental Hy	giene 2 (40864			
			 Registrar Decedent's Name (First, Middle, Last 	st)	<u></u>	tillCa	le oi D	cauı	2. Date of Dea			3. Time of Death			
	Physicia Medic		Frances M. Muelle	r					Month 11/	25/201	2 Year	1517 M			
	Examin		4a. Facility Name (if not institution, give AAMC	street and number)		4b. Cit	y, Town, or Annap	Location of Death		4c. Cour	ity of Death ne Art	ındel			
	Funeral Director		5. Social Security Number 212-05-2509 Usual Residence of Decedent	ex 7. Age (n) y □ M 2√√√√ F	95 Yrs.	If Und Month	ler 1 Year B Days	If Under 24 Hrs, Hours Min.	8. Date of Birt (Month, Da 8/15/	y, Year)	9. Birth Cour	place (State or Foreign htry) MD			
	and show	ō	10a. State 10b. County	100	. City, Town or Lo	cation					1	10d. Inside City Limits			
	Maryli 28a-f ptifiec	Director	MD Anne A	runde1		S	everna	a Park				1 ☐ Yes 🗶 No			
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	ns 2: ms 2: must	Funeral	160 Boone Trail	140 W. D. J. J. J.		Van Dan	- 44 -610	21146	!f . \/ \ \	12	USA				
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show my injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ★ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 XXXIII Yes, Give Year or Dates.		If Yes, sp	edent of His ecify Cubar 2 KMNo	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)		ace - Americ lack, White, fy:				
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Baltimore,	permit Depart Impor any in		Dur Lady of the Fields 11/29/2012 Millersvill 21. Signature of Fuperal Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, 12 Ridgely Ave. Annapolis, MD 21401												
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Box 6876	Hospital or Attending Physician: The law requires that the death certificate by 4 hours after death. Funeral Director: After this certificate has been signed by the attending physically filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pre 1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ctopi		<u>'</u>			Date of deliv Month	Pery Day Year			
P.O.	hat th ed by detac	y Ph	Part II. Other significant conditions of	ontributing to death but no	t resulting in the u	underlyin	g cause give	en in Part I.	23e. Did to	obacco use co	ntribute to t	he cause of death?			
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Division of Vital Records,	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director, After this completely filled in by the funeral di	Medical Certificate:	27. Manner of Death 1			М		at ? Yes 2 □ No	28d. Describe h	ow injury occu	rred				
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	To the within To the compli	Σ	only one) 3 L Certifying Nurs 29b. Signature and title of certifier	se Practitioner: To the bes	of my knowledge		ocurred at the Oc. License			he cause(s) and 29d. Date sigr					
			ì	200 Mars			D	68222		3.	11/2	8/12			
	34.		30. Name and address of person who	completed cause of death	Item 23a) (Type, F	Print)						1			
_				2001 MEDIC	th DAR	KW	ty A	WNAPOL	S MO						
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's S	gnature	Sax	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 234 20**T**2 07:30 PM Cecil P. Moran Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel 410 Hamlet Club Drive, #207 Edgewater 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Days Director 578-42-9575 1**X**□M2□F 81 Yrs. 7/2/1931 Washington, D.C Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinat must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Anne Arundel 1 Yes 2 No Maryland Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21037 410 Hamlet Club Drive, #207 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in 0.5.

Armed Forces?

1 ₺ Yes 2 □ No
If Yes, Give
Year or Dates. 1949-53 Black, White, etc. 1 Never Married 2 Married Š 1 ☐ Yes 2 🛛 No Specify: White Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Technical Review Engineer Federal Government Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Lillian Prather Cecil P. Moran, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie B. Stein / Cousin 300 South River Landing Rd., Edgewater, MD 21037 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 11-29-2012 Edgewater, Maryland Kalas Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CORONARY APPERY DISEASE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): WER UPIDEMIA attending physician and for use as the burial-transit Cause (Disease or injury that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day signed by the at 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been signampletely filled in by the funeral director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) ٩ 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 A Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my original death occurred at the Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print).

KEVIN T. O'KEEFS MD ZOOZ MEDICAL PARKWAY SVITE 100

State

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Registrar DHMH 17 Rev 06-2011 31. Date filed (Month, Day, Year) NOV 2

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Nelago saymond Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 805 Coxswain Way, #205 Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 1/9/1923 **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 182-14-2579 Director 1 🔀 M 2 🗆 F 89 Yrs. Pennsylvania Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits 10c. City. Town or Location within 72 hours after death with the Maryland Director 1 🗆 Yes 2 🙀 No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 805 Coxswain Way #205 USA 21401 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates.1943-46 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 X No Specify: Specify: White 3 K Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Printer Government Printing Office permit. Pege 1 end 2 should be filed win Department of Health and Mental Hygie Important: If item 27 is marked other amy injury or other traumatic event, 1000. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Julia Zahronsky Michael Melago 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 808 Oak Grove Circle, Severna Park, MD 21146 Mark Melago / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Varyland Veterans Cemetery 11/30/12 Cheltenham, Maryland 4 Donation 5 Other (Specify) 21. Signature of uneral Service License 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part 1. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheet, or heart failure. List only one cause on each line. Immediate Cause (Final nsot and Death Physician/ ORDNAR disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Completed by Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlel-transit ettending physician and for use as the burlei-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Dav 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🗆 No 25. Was case referred to medical Medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 2012 eted cause of death (Item 23a) (Type, Print) 24 ICHAET 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

NOV 29 2012

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

le.

12-09123	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legib
Anthony David Neal	State of Maryland / Department of Health and Mental Hygiene
4 10 4	

		1- For State Registrar	Ce	ertificate of		id Wichtai i		g. No. 2	112	1.086
Physicia Medical Exami	****	Decedent's Name (First, Middle,Last)					Date of Deat Month		ır 3	. Time of Death
Miedicai Exami	ner	Anthony David 4a. Facility Name (if not institution, give:	Nea1	14	h City Town o	r Location of Deat	Month December	1, 2012 4c. County of		0238 hrs
		Meritus Medical Center	or cot and named ,		Hagerstow			Washing		
Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs.	2.6	If Under 1 Year Months Day			h (MM/DD/YYYY	1 Foreign	•
		215-17-5834 1X N	1 2 F	36 Yrs.			July 3	0, 1976	Coun	try)Maryland
, any		10a. State 10b. County	10c. City	y, Town or Locatio	n				1	0d. Inside City Limits
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r death with the Maryland or items 23a or 28a-f show must he notified at once.		20834 Reno Monume	nt Road 12. Was Decedent Ever in t	IS 13 Was	21713	ispanic Origin? (S		U.S.A.	America	n Indian, Black,
death v r item	Funeral	1 Never Married 2 Married	Armed Forces? 1 Yes 2 X No			n, Mexican, Puerto		White		ir malan, black,
after all, o	by F	3 Widowed 4 Divorced	Yes, Give Year	1	Yes 2 X No	specify:		Specify:	Wh	ite
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5-00 led wi Hygier other		17. Father's Name (First, Middle, Last)		_1			e (First, Middle, M	I laiden Surname))	
d be fi fental arked event,	Be	Martin W. Neal 19a. Informant's Name/Relationship (Type	Sr.	40, 14, 7		Sandra	L. Heb			
MD 21215-0036 of 2 should be filed within 7 th and Mental Hygene. n 27 is marked other than numatic event, the Medical	٩	Sandra L. Neal / m		118111		et and Number or Onument I				
e, N 1 and 3 Health item :	- 1	20a. Method of Disposition	20b.	Place of Disposit crematory or other	ion (Name of ce		Date	20c. Location -		
MOF Pages nent of unt: If		1 X Burial 2 Cremation 3 4 Donation 5 Other Specify:		rmony Ch		m 12/	06/2012	Myersvi	11e,	Maryland
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Sunature of Functul Service License	nd21			s of Facility Bas				
Physician	-	23a. Part / Enter the disease, or complic	ations the caused the deat			ational				21713 Approximate Interval
/Medical		failure. List only one cause on each	ufine. eck Injury		, ,	,	,	,		Between Onset and Death
Examiner		PO 10 1 1 1 1 1 1	ue to (or as a consequence	of):						
	ē	Sequentially list conditions, if any, leading to immediate b	ue to (or as a consequence	of):					-	
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	ue to (or as a consequence	of):						
760, cate be executed physician and he burial - transit		events resulting in death) Last d.								
68760, certificate be executed nding physician and se as the burial - transi	Medical		AMENDED				-			
876 tificate ng phy as the l		23b. Was decedent pregnant in the	23c. If yes, outcome of pre-		al death 3	Ectopic pregn	ancy	23d. Date of Month	delivery Day	/ Year
OX 6 ath cer attendi	Physician/	past 12 months? 1 Yes 2 No 9 Unknown	4 Pregnant at time of d		er (Specify)					
D. B. It the de by the	P		9 Unknown ontributing to death but not	resulting in the un	iderlying cause	given in Part I.	23e. Did to	bacco use contri	bute to the	cause of death?
, P.(res that signed be det	d by					· · · · · · · · · · · · · · · · · · ·	1 Yes	2 ✔ No 3	Probab	oly 4 Unknown
ords v requi s been should	Sete						24a. Was a			osy findings available opposition of cause of
Recc The lay cate ha	Completed						perfor 1 ✓ Yes 2	med? d	eath?	2 No
cian:	Be	25. Was case referred to medical examiner?	spital:			e of Death (Check				
of Vi Physi ter this eral dir	P	1 ✓ Yes 2 No 27. Manner of Death	i inpatient 2	ER/Outpatient 28b. Time of Inj		Other Nursi	ng Home 5	Residence 6	Other:	
Division of Vital Records, P.O. Box 687 ral or Attending Physician: The law requires that the death certific rs after death. al Director: After this certificate has been signed by the attending pled in by the funeral director, page 2 should be detached for use as the	Certification:	1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) Dec 1, 2012	0147 hrs		Yes 2 🗸 No		o involved in		n
VISI or Att or Att or Att	ifica	2 Accident Investigation 3 Suicide 6 Could not be	28e Place of Injury - At I	home, farm, street	, factory, office	building, etc.			er or Rural	Route Number, City
Dispital hours a neral	Ser	4 Homicide determined	(Specify) Major Roa	ad / Highway			or Town, St Dual Highway	west of Crestv	iew Road	d, Hagerstown, MD
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as the	Medical	one) 2 Medical Examiner: 0	To the best of my knowled on the basis of examination							
To viii	Me	29b. Signature and title of certifier	nd manner stated.		29c. Licen:	se number		29d. Date signe	ed (Month	, Day, Year)
		J.M.	A.E.		O.C.	M.E.		December :	2, 2012	
8-WT	ļ	30. Name and address of person who co	inpleted cause of death (Iter	,	altimom Str	eet Baltimare	MD 21222	<u> </u>		
-	ate	31 Date filed (Month Day Year)	32 Registrar's Signal		animole off		, IVIL Z 1223			
Regist	rar	DEC 0 4 20	MZ Amend	A. Art	Made					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 29 Physician/ Joseph Orenstein 2012 November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2012 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Director None 1 X M 2 □ F 9 Yrs November 28 Maryland Usual Residence of Deced 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location Director Ellicott City 1 Yes 2 No Howard 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number Funeral 21043 USA 4341 Stonecrest Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White 3 Divorced 4 Divorced Year or Dates 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Never Worked None 0 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) ဂ္ Faye Orenstein Lisa Unavailable 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) 4341 Stonecrest Drive, Ellicott City, MD Mother Lisa Faye Orenstein 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 12/04/2012 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Atlanti<u>c Crematory</u> 22. Name and Address of Facility Cole Funeral Services, P.A. e of Funeral Service 4110 Aspen Hill Rd.#100, Rockville, MD 20853 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter the diseas shock, or heart failure Immediate Cause (Final Physician/ disease or condition resulting in death) Acidosis Metabolic Medical Due to (or as a consequence of) Examiner Asphyxia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Overwhelming Sepsis or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 9 Unknown 5 Other (specify) signed by the at Id be detached fo 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed been signal 24b. Were autopsy findings available prior to completion of cause of death?

1

No

No 24a. Was an s certificate has be director, page 2 s autopsy performed? 1 X Yes 2 ☐ No 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ER/Outpatient 3 DOA 1 Tes 2 🔀 No မ 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 8c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After to completely filled in by the funer injury 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

Registrar DHMH 17 Rev 06-2011

State

29b. Signature and title of certifier

Dora C.

1500 Forest Glen Road, Silver Spring, MD 20910

a720

egistrar's Signature

count

M.D.

32

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rioja-Mazza

4

29d. Date signed (Month, Day, Year)

012

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Pleas	se Type or									_	e.	
		For State Registrar	State	or iviary	yland / Dep Ce	ertificat			and iv	тептат пу	Reg. No	201	2 41	1869
Physicia Medic		1. Decedent's Name (First, Middle, Elizabeth	Last) Adaeze	<u> </u>	Offodi	le_				2. Date of De Monta 1/	eath			e of Death 20A _M
Examin		4a. Facility Name (if not institution, g		nber)		4b. City,	Town, or per 1	Location of Mar1b	of Death OrO		Pr	County of Do	eorge'	S
Funeral Director		5. Social Security Number 611-15-3809 Usual Residence of Decedent	5. Sex 1 ☐ M 2 🔏 F	7. Age (In	yrs. last birthday Yrs.) If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 12/19/	th ay, Year) 1942	9. 1	Birthplace (Sta Country) Nige	te or Foreign ria
Maryland 28a-f show otified at	Director	10a. State 10b. County	e George		oc. City, Town or Upper Ma)							e City Limits Yes 2 XX
with the 23a or	Funeral D	10e. Street and Number 1400 Mute Cour	t			10f. Zip		774			10g. Cit	tizen of What USA		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Deparatrent of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3√3 Widowed 4 ☐ Divorced	12. Was Dece Armed For 1 Yes If Yes, Giv Year or D	orces? 2 🔼 No ve	în U.S. 13	. Was Deced If Yes, spec	ify Cubar	n, Mexicar	n, Puerto	cify Yes or No- Rican, etc.)		14. Race - Ai Black, W	merican Indian nite, etc. Black	,
within 72 hour	Completed	15. Decedent (Specify only highest Elementary/Secondary (0-12) 12			(Giv life.	edent's Usua e kind of woi DO NOT use .f—Emp.	k done d retired)	luring mos	t of worki	ng	10	ind of Busine	ss/Industry	
Id be filed v Mental Hyg larked othe atic event,	To Be	17. Father's Name (First, Middle, La Boniface Okafo	,					18. Moth		e (First, Middle, Onuzi				
nd 2 shou ealth and m 27 is m		19a. Informant's Name/Relationship Rita Offodile /		r		_		urt U	pper	Route Number Mar1bo	_			74
Page 1 ament of Hamt of Hamt: If ite		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Sp	3 👿 Removal from	State	20b. Place of Dis cemetery, cr Offodile	ematory or o	ther place		Unk.	Date	[ocation - City ka, Nig	or Town, State geria	
permit. Depart Import any inj once.		21. Signature of Funeral Service Lice	censee		6	22. Name an	d Addres	s of Facilit Hill	y Geo Rd.	rge P. Oxon Hi	Kala ill,	as Fune Maryla	eral Ho and 207	me PA 45
Physician/		23a. Part 1. Enter the disease, or c shock, or heart failure. List on Immediate Cause (Final disease or condition	omplications that ly one cause on ea	ach line.	e death. Do not en		e of dying	g, such as	cardiac o	r respiratory ar	rest,		Approxii Interval Onset ai	Between
Medical Examiner		resulting in death)	Due to		nsequence of):									
uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	(or as a co	nsequence of):									
te be executed nysician and he burial-transit	<u>a</u>	resulting in death) Last	Due to	(or as a co	nsequence of):									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2XXNo 9 ☐ Unknown	23c. If yes, ou 1 Live 4 Preg 9 Unk	Birth 2 ☐ nant at tim	Fetal death 3	☐ Ectopic p	oregnance ec <i>ify)</i>	у				23d. Date of Month	delivery Day	Year
uires that the signed by	by	Part II. Other significant condition	s contributing to c	leath but n	ot resulting in the	underlying	ause giv	en in Part	l.				to the cause of	
The law require has been bage 2 shou	Completed									24a. Was auto perfo		prior t	autopsy finding o completion o ? fes 2 \(\sum \) No	gs available of cause of
sician: certifica	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2XXNo	Hospital:				Othe	nce of Dear		only one)				
ding Phys th. After this funeral d	cate: To	27. Manner of Death Natural 5 Pending 2 Accident Investiga	28a. Date (Mon		2 ER/Outpati 28b. Time injury		Bc. Injury work	4 ∐ Nu	1	me 5 🗶 Resi			ecify)	
al or Atten s after dea I Director ed in by the	Certificate:	3 Suicide 6 Could no 4 Homicide determin	ot be 28e. Place	of Injury - ing, etc. (S	At home, farm, s pecify)					28f. Location (8 City or Tov			Rural Route Nu	mber,
he Hospit in 24 hour he Funera ipletely fills	Medical	(Check 2 L Medical Ex	Physician: To the bar aminer: On the bar lurse Practitioner	sis of exam	ination and/or inve	estigation, in	ny opinio	n, death oc	curred at	the time, date a	and place	, and due to th	e cause(s) and	manner stated.
		29b. Signature and title of certifier M.5 Ry 30. Name and address of person wi	yahre.	MD			License D	number 00574	65			te signed <i>(Mo</i> 23/2012	nth, Day, Year)	
45:4		30. Name and address of person when NS Rajapakse M	no completed cause	se of death Smith	(Item 23a) (Type Ave. #2	Print) 203 Ba	ltim	ore,	MD	21209				
Stat Registra	e ar	31. Date filed (Month, Day Year)	012	legistrar's	Signature	uli								

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^{Day} 28 2012 19:34PM Ernesto Torres Penaranda Nov. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Southern Maryland Hospital Clinton Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year) Hours Min. 5714 224 43 Director 1 M 2 □ F 79 04/17/1933 Philippines Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State irector Fort Washington MD Prince George's 1 Yes 2 No ۵ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera USA 20744 1205 Huntersmill Ave. death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 K Married \$ Maryland 21215-0036 72 hours after Specify: Asian 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) at Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Private Hotel Worker e 1 and 2 should be filed wit of Health and Mental Hygie If item 27 is marked other or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Inocencio Penaranda Teodora Torres 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Librada Penaranda/ Wife 1205 Huntersmill Ave.Ft.Wash., MD 20744 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Page 1 permit. Page 1 Department of Important: If it any injury or o 1 🗆 Burial 2 🖾 Cremation 3 🗆 Removal from State 12/4/2012 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crem. Signature of Funeral Service License 22. Name and Address of FacilityBriscoe-Tonic Funeral Home 2294 Old Washington Rd.Waldorf, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year ☐ Yes 2 ☐ No detached the g Unknown g Unknown P.O. à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed b 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown cate has been sig ; page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 M No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗹 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 8c. Injury at 28d. Describe how injury occurred After t 1 Matural 5 Pending To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 V Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practition of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D72997 R 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7503 Sunil Swami Surratts Road Clinton, MD 20735 31. Date filed (Month Registrar's Signat State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40871 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Рм 5:00 Rose G. Prakas November 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3100 N. Leisure World Blvd., Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Director 145-14-6215 1 M 2 XF 88 June 8, 1924 New Jersey Usual Residence of Deci i and 2 should be filed within 72 hours are...
if Health end Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f show
item 27 is marked other than "hadical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Silver Spring Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 3100 N. Leisure World Blvd., #916 20906 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 White 1 ☐ Yes 2 H No Specify: If Yes, Give 3 ₩ Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) US Navy Dental School <u>Media Librarian</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Andrew Zacharias Violetta Felis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Georgia P. Dandeneau/Daughter 7009 Deer Valley Road, Highland, MD 20777 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)

Gate of Heaven Cemetery 2012 Important: If its any injury or of once, Page 1 ō 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State 30, 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility. Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Hypertensive Cardiovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate raise. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the hourst account. ed by the attending physician and detached for use es the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Pregnant at time of death 5 Other (specify) Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 🔯 No 3 🗎 Probably 4 🗀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No 1 Tes

Box 68760 P.O. Records,

Completed by Be ဂ္ဂ Certificate:

Medical

Division of Vital

25. Was case referred to medical

1 ☐ Yes 2 🔀 No 27. Manner of Death

29a. Certifier

only one

1 Natural
2 Accident
3 Suicide 5 Pending 4 Homicide

Investigation 6 ☐ Could not be determined

 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practitioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

28a. Date of injury (Month, Day, Year)

M.D.

D27660

28c. Injury at

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5XXResidence 6 Other (Specify)

28d. Describe how injury occurred

City or Town, State)

29d. Date signed (Month, Day, Year) 12 26

28f. Location (Street and Number or Rural Route Number,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11125 Rockville

Alpana Goswani, MD 31. Date filed (Month, Day, Year) NOV 29

1 Inpatient 2 ER/Outpatient 3 IDOA

28b. Time of

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ederico Mendez		rez S	tate of Maryla		artment of			Menta	al Hyg	giene	J	0.1	0 1007
Physiciar		Registrar 1. Decedent's Name (First, Midd	ile,Last)		rincale or	Dealli			12	. Date of Dea	Reg. No.	Ul	3. Time of Death
Medical Examin	v.	Federico	Mendez	Pere	Z							ear	1330 hrs
manufat .	ı	4a. Facility Name (if not instituti 12911 Gaffney Road	on, give street and n	umber)	-	b. City, To		ocation of I			4c. Count	•	h
mark _		5. Social Security Number	6. Sex	7. Age (In yrs.	last histhday)	Silver S		If Under 2	24Uro	9 Data of B	Montg		rthplace (State or
Funeral Director		none	1 M 2 F	23	Yrs.	Months		Hours	Min.				Guatemala Sunity)
	ļ	Usual Residence of Decedent										<u> </u>	
Maryland 28a-f show aoy d at oocc.	ctor	MD 10b. County Prin 10e. Street and Number	ce Georg		, Town or Locati Hyatt						10g. Citizen of V	What Cou	10d, Inside City Limits 1 Yes 2 No
ith the Maryland 23a or 28a-f sho notified at ooce	힐	8242 14th A	venue	Apt	.101			783			Guat		•
er death wi	Eng	11. Marital Status 1 X Never Married 2 N 3 Widowed 4 Di		2 X No	If Yo	s Decedent es, specify (Cuban, M G ʻu	Mexican, P	uerto R			ite, etc. V	rican Indian, Black, Vhite
hours at natural		15. Decedent's Education (Spe	or Dates:		16a. Deceden		ccupation	n (Give kir	nd of wo	rk done	16b. Kind of		/Industry
7	Completed	Elementary/Secondary (0-12)		1-4 or 5+)		abor	er				Land		pe
	å	17. Father's Name (First, Middle Santos Luci 19a. Informant's Name/Relation	ano Mend	lez Uri		A dd		Ju	ana	Pere	Maiden Surnar		
MD 2 d 2 shoul tht and h a 27 is m unmatic		Jose Raul Oc		end	2005	Sum	mer:	set	st.	Hyatt	mber, City or To	own, State P, Md	e, Zip Code)
ire, s l am f Heal If iten			Other Specify: El Rincon 12/5/2012 Guatema										Town, State El Quiche ala
Baltimo permit. Page Department o Important: injury or ott		21. Signature of Funeral Service	Livenson		22: H	ame and Ad	ddress o	K PNYA	LDI	FUNE	ERAL SI	ERVI Spri	CE,P.A. ng,Md2091(
Physician /Medical -xaminer		23a. Part I. Enferthe disease, o failure. List only one cause Immediate Cause (Final diseas)	e on each line.		. Do not enter th								Approximate Interval Between Onset and Death
Adminer	- 1	or condition resulting in death)		a consequence o	र्ज):								
	ler L	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause		a consequence o	of):								
nd d	Exam	(Disease or injury that initiated events resulting in death) Last	C.	a consequence o	of):								
be executed be executed sician and nurial - transi	dica	UNPENDED	AMENDED							-			
6876(certificate inding phy.	Sician/	IF FEMALE: 3b. Was decedent pregnant in 1 past 12 months? 1 Yes 2 No 9 Ur	he 1 Live I	nant at time of de	2 Fel	al death ner <i>(Specif</i>)		Ectopic p	regnand	cy	23d, Date Month		y Day Year
P.O. E	2	Part II. Other significant condi		o death but not r	esulting in the u	nderlying ca	ause giv	en in Part	l.				the cause of death?
2 8 8 7	Completed									24a. Was	psy ormed?	prior to death?	utopsy findings available completion of cause of
		25. Was case referred to medical	al T			26	Place of	f Death (C	heck on	1 Yes	2 No	1 🗸 Y	es 2 No
Vita	90	examiner?	Hospital: 1	Inpatient 2	ER/Outpatient			ther ₄ N		<u> </u>	Residence 6	✓ Othe	r: Scene
ision of Vital rdeath rdeath rector: After this certif by the funeral director,		27. Manner of Death	28a. Date (Month Nov 16	of Injury h, Day Year) , 2012	28b. Time of Ir 1318 hrs		c. Injury	at Work?	2	8d. Describe	how injury occu from tree	ırred	
Division tal or Attendi rs after death. al Director: /	Certification:	2 Accident Inve	estigation	ce of Injury - At h	ome, farm, stree				2	or Town,			ural Route Number, City
	ا ق	29a. Certifier 1 Certifying F	Physician: To the beaminer: On the basis	st of my knowled of examination a					e, and di	ue to the cau	se(s) and mann	er as stat	ted.
	¥ed -	29b. Signature and title of certifi	and manner s	stated.			_icense r						onth, Day, Year)
2		Par a	- Pol	Q			O.C.M.	.E.			Novembe		
		30. Name and address of person Patricia Aronica-Polla		se of death (Item	,	900 \// 5	Raltima	ore Stro	et Pa	ltimore M	ID 21222		
Stat	te	31. Date filed (Month, Day, Year,	32. R	egistrar's Signati	Contract of the Contract of th	300 VV. E	-ailiiii(ci, Da	iamore, iv	ID 61669		
Registra		NOV 292	J12 Sener	un for	Car areas								

12-09312	
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Berthony Petit-Homme

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	,	Cer	tificate of	Death			R	teg. No.	20	! 4	4001
Physicia fledical Exami	an/	1. Decedent's Name (First, Middle Berthony Peti							2. Date of Dea Month Decembe	eth Day	Year	:	3. Time of Death 2216 hrs
		4a. Facility Name (if not institution 2209 Glenallen Avenu	-	er)	4	b. City, Tov Silver S	vn, or Location Spring	of Death			County of I		
Funeral Director		5. Social Security Number 219–11–9880		Age (In yrs. Ia	st birthday) Yrs.	If Under		der 24Hrs. rs Min.	8. Date of Bi		1 _F	oreign	place (State or
' any		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Location	on	· · · · · · · · · · · · · · · · · · ·					- 1	10d. Inside City Limits
Aaryland 28a-f show i at once.	ģ	MD Mon	tgomery		Silver	Spr			1.4	10a Citia	zen of What		1 Yes 2 No
th the Maryland 23a or 28a-f sho	Director	2209 Glenallen	Avenue, Ap	t. 202	2	2090				USA		Count	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she maric event, the Me iteal Examiner must he notified at once	Funera	11. Marital Status 1 Never Married 2 MM	1 Yes		If Ye	s, specify (Cuban, Mexica	n, Puerto	Specify Yes or No- o Rican, etc.) 14. Race - American II White, etc. Specify: Black				
ours afte	à	3 Widowed 4 Div 15. Decedent's Education (Spe	orced If Yes, Give Year or Dates: cify only highest grade c	ompleted)	16a. Decedent		cupation (Give	e kind of w	kind of work done 16b. Kind of Busir				
136 hin 72 ho e. than "na than Ex	Completed	Elementary/Secondary (0-12)	College (1-4 o	or 5+)			ng life. DO NO C ialist		ed)	Fe	Go	vernment	
MD 21215-0036 d.2 should be filed within 72 tht and Mental Hygiene. n. 27 is marked other than numaric event, the Me lical	Com	17. Father's Name (First, Middle,	· ·	<u>.</u>	or unit	Брес			(First, Middle,			. 00	VCIIIMCIIC
d be fill fental Harked	o Be	Geleber Petit 19a. Informant's Name/Relations			Table Mailing	A 44			ıcienne				
MD 2 2 shoul th and N 27 is m	ř	Monica G. Peti		e									Zip Code) 2090 Spring,MD
Fe, s 1 an of Heal		20a. Method of Disposition 1 X Burial 2 Cremation	n 3 Removal from	of cemetery,	De	Date	1	ocation - C	ity or T	own, State			
Baltimore, permit. Pages 1 at Department of He. Important: If ite		4 Donation 5 Other St 21. Signature of Funeral Service	Licensee	bace	of Hea			<u>1</u>	2012 Funera	Si1			ng, MD
		23a. Part I. Enter the disease, or	11	ad the death	500	Univ	ersity	Blvd	. W, . :	Silv	er Sp	rin	g, MD 2090 Approximate Interval
Physician Medical xaminer		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line.	Arrhyt	hmia	e mode or c	aying, addiras	cal diac or	respiratory arr	1631, 3110	on, or riedit		Between Onset and Death
	<u>_</u>	Sequentially list conditions, if any, leading to immediate	b									4	<u> </u>
	Examiner	cause. Enter Underlying Cause (Disease or injury triat initiated events resulting in death) Last											
ecuted transit			d		<u> </u>	226.2	00.10						
50, te be ex nysician	Medical	X UNPENDED IF FEMALE:	AMENDED 23a			936 2	-20 - 13	sm		1 224	l. Date of de	divoru	
Box 68760, ce death certificate be executed the attending physician and edfor use as the burial - trans	Physician/N	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant	at time of dea	2 Feta	al death er (Specify		oic pregnar	ncy		Month	Da	ay Year
that the de detached f		Part II. Other significant condit	9Unknown		sulting in the ur	nderlying ca	ause given in P	Part I.	23e. Did t	obacco i	use contribu	ite to th	ne cause of death?
ords, P.O. w requires that the same of the	ed by												ıbly 4 ✓ Unknown
2 a 2 C	Completed			<u> </u>					24a. Was autop perfo 1 Y Yes	psy orm <u>ed</u> ?	prio dea		ppsy findings available mpletion of cause of 2 No
ital Rec itcian: The l s certificate l	a	25. Was case referred to medica examiner?	Hospital:	tient 2	ER/Outpatient		Place of Death	_		Dooida	nce 6 🗸	Others	C
of Ving Physi	일	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Ir (Month, Day	niury	28b. Time of In		. Injury at Wor		28d. Describe	·			Scene
Sion Attendi r death. ector:	ertification:		ding stigation		me, farm, street		Yes 2		28f Location /	Street a	nd Number	or Pure	al Route Number, City
Divising the pital or At ours after do ceral Direct filled in by	Sertif	4 Homicide dete	d not be rmined (Specify)	injury - At the		i, raciory, o	mos banding, c		or Town, \$		no ramber	or real	arrodic (valider, ony
To the Hos within 24 h To the Fun completely	edical (hysician: To the best of miner:On the basis of ex	xamination ar									
		29b. Signature and title of certifie	and manner state	d.		29c. L	icense numbe	ır		29d. E	Date signed	(Mont	h, Day, Year)
1-lea		Molling and address of	Branelf.M	(doa'h (i'i	220)		D.C.M.E.			Dec	ember 7,	2012	<u> </u>
		30. Name and address of person Melissa Brassell, MD	Assistant Medic	•	er 900 W.		re Street, E	Baltimor	re, MD 212	23			
St Regis		31. Date filed (Month, Day, Year)	012 2. Regist	trar's Signatu	to sail	ø,						-	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				ryland / Depa			лental Hygie	ene	2 40874					
			State Registrar	Registrar Certificate of Death Decedent's Name (First, Middle, Last)										
	Physicia	in/	Rose Magdalene Plume				2. Date of Death Month	Day 4, 2012	3. Time of Death					
-11	Medic Examir		4a. Facility Name (if not institution, give street and number)		4b. City. Town. or	Location of Death	December	4, 2012 4c. County of Dea	6:30 A M					
_	LAGIIII	Ž.	Twin Oaks Assisted Living		William			Washing						
	Funeral		5. Social Security Number 6. Sex 7. Age	In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yo	9. Bi	irthplace (State or Foreign ountry)					
	Director		220-09-7122 1 □ M 2 🔀 F 89	9 Yrs.			12/15/19		ryland					
	and show d at	힏		10c. City, Town or Loc	cation		1		10d. Inside City Limits					
	Maryl 28a-f otifie	Director	MD Washington	Hagersto	own				1 🏝 Yes 2 🗌 No					
	th the 3a or 1 be n	al D	10e. Street and Number		10f. Zip Code			g. Citizen of What C	Country?					
	ath wi	Funeral	1005 Security Road 11. Marital Status 12. Was Decedent Evi	erin II S 13 M	21740 Vas Decedent of Hi			USA 14. Race - Am	erican Indian					
9	ter de or ite mine	by F	Armed Forces? 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ N	o If	Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Black, Whi						
003	urs af ural", al Exa		3 ☐ Widowed 4 ☐ Divorced Year or Dates.	1	☐ Yes 2X No	Specify:		Specify:	White					
15	72 ho n "nat	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occupa kind of work done a D NOT use retired)		ing 16	6b. Kind of Business	s/Industry					
212	within jiene.	S	Elementary/Secondary (0-12) College (1-4 or 5+)		nemaker			Home						
nd	filed all Hyg	o Be	17. Father's Name (First, Middle, Last)				other's Name (First, Middle, Maiden Surname)							
yla	uld be I Ment narke	은	Charles William Langenstei				B. Cook							
Mai	2 shouth and the and the strain traum	i	19a. Informant's Name/Relationship (Type, Print)					ity or Town, State, Z $_1$, MD 2174						
e,	f Health tem 27 other tra		Gilbert A. Plume / Husband 20a. Method of Disposition	20b. Place of Dispos	sition (Name of	1		oc. Location - City o						
mo	Page nent o ant: If Iry or		1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	cemetery, crem Rose Hill	cemetery	·	/2012 H	agerstown	ı. MD					
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	22.	. Name and Addres	ss of Facility Ge	rald N. M	linnich Fu	meral Home					
ш	⊈ <u>e e</u>		23a. Part 1. Enter the disease, or complications that caused the			*		town, MD	21740					
	Medical Examiner	Examiner	cause. Enter Underlying	Insequence of):	nive	heart	dise	are	Interval Between Onset and Death					
3760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical	d	consequence of):										
). Box 687	ss that the death certificat igned by the attending ph be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of 1 ☐ Live Birth 2 4 ☐ Pregnant at t	☐ Fetal death 3 ☐	Ectopic pregnanc Other (specify)	у		23d. Date of de Month	elivery Day Year					
P.O.	gned k	by P	Part II. Other significant conditions contributing to death but	not resulting in the ur	nderlying cause giv	en in Part I.	23e. Did tobac	3	o the cause of death?					
rds	requires been sig should b	eted	Cere sto vancula	No and	Icani		1 Yes	2 No 3 L I	Probably 4 Unknown					
Division of Vital Records,	sician: The law r certificate has b director, page 2 sk	Completed	25. Was case referred to medical	lecin			24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of					
Vita	ysician: s certific director,	To Be	examiner?	t 2 ER/Outpatient	Othe	ace of Death (Chec	, , , ,	ce 6 Nother (Spe	assisted will					
on of	I or Attending Phys after death. Director: After this.	Certificate: T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day,	28b. Time of	28c. Injury work	at at	28d. Describe how		city five no descent					
Divisi	pital or Att ours after d eral Direct filled in by i		building, etc. (City or Town, S							
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of m 2 Medical Examiner: On the basis of exa 3 Certifying Nurse Practitioner: To the basis of exa	mination and/or investi	gation, in my opinio	n, death occurred a	t the time, date and p	place, and due to the	cause(s) and manner stated.					
	5 ± 5 10 10 10 10 10 10 10 10 10 10 10 10 10		29b. Signaty ∂ and title of perfilier		29c. License			Date signed (Mont						
	300		30. Name and address of person who completed cause of dea	th (Item 23a) (Tune Pr	rint)	00031	- > >	12/04/	2012					
			Shabid Mahmood 52	OC Nor	Them,	Ave Har	erstown	MS 2	1742					
	Stat Registra		31. Date filed (Month, Day, Year) 2012 32. registrar's	s Signature	and I									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2013 Alfred Pierce Bruce Medical 4a. Facility Name (if not institution, give street and number) **Examiner** City, Town, or Location of Death 4c. County of Death Lowote Juliallamor Healthcare Haberg Washington 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Unde **Funeral Director** 414-46-9046 1 XM 2 - F 84 July 13, 1928 North Carolina Usual Residence of Decedent 28a-f show 10b County 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 X Yes 2 No Maryland Washington Hagerstown 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 131 Chantilly Court 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 1951—
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify. White 1959 Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done life. DO NOT use retired) (Specify only highest grade completed) during most of working other than Elementary/Secondary (0-12) College (1-4 or 5+) of Health and Mental Hygiene. Manager Publishing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Dorothy Helen Graves Lee Felia Pierce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris E. Pierce / wife Chantilly Court Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Important: If it any injury or or once. 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Stauffer Crematory 12/06/2012 | Frederick, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Bast-Stauffer Funeral Home, alls 7606 Old National Pike Boonsboro, MD 21713 Part 1. If ter the disease, or complication shoot or heart failure. List only one of 23a. Part 1 aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. ach line Immedi de Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Completed by Physician/Medical Examiner Cause (Disease or injury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician P.O. Box 68760 for use as yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Benian ProstAtic Hypertrophy Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed' 1 Yes 2 000 Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical funeral director, Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 2 XNo 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural work 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation Could not be filled in by the within 24 hours after deat To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check 3 🗹 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 333 MillStreet, Haverstown, MD 21740 JW-101 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Elmer Elmo Powell 12012 Z Day 2115pm Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOSPICE A+ Coastal Salisburg the L WICOME . Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Min. 218-16-7175 97 Hours 1 QM 2 □ F Director 08/19/1915 Maryland I Hygiene. I ther then "neturel", or iteme 23a or 28a-f shov vent, the Medical Examiner must be notified at 10b. Count flied within 72 hours efter death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Wicomico Salisbury 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? United States Funeral 21804 200 Civic Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14 Race - American Indian 1 ☐ Yes 2 ☐ No If Yes, Give Black, White, etc. β 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Transportation Mechanic t. Pege 1 and 2 should be filed with tranent of Heelth end Mentel Hygiel trant: If item 27 le marked other 1 jury or other traumetic event, th Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Syrname) Ethel Mariner Powell Walter F. Powell 19a. Informant's Name/Relationship (Type, Print)
Richard Powell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son 29530 Stillwood Dr., Delmar, Md. 21875 timore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Pege 1 s Depertment of H Important: If ite any Injury or ot Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State St. Andrews Episc. CEM. 11/28/2012 Princess Anne, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Bai 22. Name and Address of Facility Hinman Funeral Home M00295 21853 673 Semerset Princess Ava. 23a. Part V Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sharm, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause Filter Underlying Cause (Disease or injury Due to (or as a consequence of) within 24 hours after deeth.

To the Funerei Director: After this certificate has been signed by the ettending physicien end completely filled in by the funerel director, page 2 should be deteched for use es the burial-transit Hospital or Attending Physicien: The lew requires thet the deeth certificete be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 2 110 1 ☐ Yes 2 🔽 1 🗌 Yes 25. Was case referred to ical examiner? 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence ြု 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Netural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 910 31. Date filed (Month State Registrar

Ch

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 12:02 AM Richard D. Pickens, II November 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Age (In vrs. last birthday) **Funeral** Days 003-54-7150 1 🗓 M 2 🗆 1-18-1962 West Virginia 50 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination. 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 X No Crofton Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral <u>211</u>14 1767 Regents Park <u>Road West</u> 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Completed by 1 X Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify Specify: White 3 🗌 Widowed 4 🗎 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Design Consultant Interior Decorating Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Babette Brooks Richard D. Pickens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1767 Regents Park Rd. West, Crofton, Maryland 21114 Babette B. Pickens/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Kalas Crematory 11-28-2012 Edgewater, Maryland 4 Donation Other (Specify) 21. Signatu Funeral 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequenc + of): Examiner Seque tially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Yes 2 No s been signed by the same should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed page 1 ☐ Yes 2 ☐ No After this certificate 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital Other: 2 🗹 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Natural 2 Accident injury 5 Pending 2 🗌 No within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Cify or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year) NOV 2 9 2012

Judy Jøseph-Herbert

30. Name and address of person who completed cause

Registrar's Signature

29a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ November 28, 2012 3:30a. M Susie R. Robinson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Holy Cross Hospital Silver Spring 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days Hours (Month, Day, Year) 233 32 2331 Director 1 ☐ M 2√√ F 01/17/1923 Alabama 89 ifiled within 72 nous and tall Hygiene defection "naturel", or items 23a or 28a-f show ed other than "naturel", or items 23a or 28a-f show es other than "naturel", or items 23a or 28a-f show ed other than "naturel" at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Directo 17 1 Yes 2 No DC Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code eral 20012 United States 710 Tewkesbury Place 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Mantal Status Armed Forces Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Mail Room Supervisor Federal Government traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file h and Mental H 7 Is marked o Celess Jones ဥ Samuel Rone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 710 Tewkesbury Pl., NW Washington, DC James F. Robinson Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1:
Depertment of I
Important: If it
any njury or of 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Cemetery 12/08/2012 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatule of Funeral Service Licensee 22. Name and Address of Facility John T. Rhines Funeral Home Washington, DC 3005 12th St., NE_ 20017 Part 1. Enter the discrete, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 23a. Part 1. Enter th Onset and Death Weeks Immediate Cause (Final Physician/ disease or condition resulting in death) Sepsis Medical Due to (or as a consequence of): Examiner weeks Osteomyelitis of Left Foot Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit Exami weeks Diabetes Mellitus Type II Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 H Unknown Completed Atrial Fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Coronary Artery Disease autopsy performed? 1 ☐ Yes 2 🖾 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2, No မ 1 & Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🖳 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 To certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 11/29/2012 D-32332

State Registrar

Se T.W

9801 Georgia Avenue, Suite 220, Silver Spring, Maryland

20902

10/0

MD

Gupta,

Surah K.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month рм 2012 Physician/ November Riedel Ε. Marjorie Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Montgomery Rockville Shady Grove Adventist Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8 Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number (Month, Day, Year) **Funeral** Months 212-20-1589 1 M 2 X F July 30, 1920 Washington, DC Director 92 Yrs 10d. Inside City Limits 10c. City, Town or Location 27 is marked other then "natural", or items 23e or 28e-f show treumetic event, the Medical Examiner must be natified at 10a. State Director 1 🗌 Yes 2 🔀 No Rockville Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Funeral 20850 9817-1 Veirs Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give SpecifyWhite 1 Never Married 2 Married Completed by 1 ☐ Yes 2 K No Specify: 3altimore, Maryland 21215-0036 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education permit. Page 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other then "ne eny injury or other treumetic event eny injury or other treumetic event eny injury or other treumetic event eny injury or other treumetic event eny injury or other treumetic event eny entered. (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) å 17. Father's Name (First, Middle, Last) Christobel Barton John Jost ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 18036 Cactus Court, Gaithersburg, MD 20877 Patricia Toombs/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Dec 2012 1XXBurial 2 Cremation 3 Removal from State Suitland, MD Cedar Hill Cemetery 4 Donation 5 Other (Specify) Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring. Signature of Funeral Service Licensee MD 20901 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, if heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part 1. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir the Hospitel or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last ettending physicien I for use es the buri Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death IF FEMALE: 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death been signed by the e should be detached t Unknown 23e. Did tobacco use contribute to the cause of death? significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 XNO 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy erei Director: After this certificate hes filled in by the funeral director, page 2 s 1 🗌 Yes 2 🗌 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 2 🗌 No Certificate: To 28d. Describe how injury occurred Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death 28a. 1 Natural 2 Acciden work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 4 | Homicide determined within 24 hours a
To the Funerei Completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier PHYSICIAN MD038002 2012 CARDIOLOGIS PINTO

Registrar DHMH 17 Rev 06-2011

State

30. Name and address of person who completed

29

31. Date filed (Month, Day, Year)

NOV

GROVE

HOSPITAL

cause of death (Item 23a) (Type, Print)

DVENTIST

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health a 1 - State Registrar Certificate of Death	, ,	2012	40880
			Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of Death	1	3. Time of Death
	Physicia Media		Sonia Weinberg ROZMARYN	Month November	Day Year 13. 2012	9:25 P M
	Examir	ner	1121 University Blvd. W., #104 Silver Spring	f Death	4c. County of Death	ery
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2 North Days Hours 1 In M 2 X F 85 Yrs.	Min. 8. Date of Birth (Month, Day, 1)	(ear) 9. Birth	nplace (State or Foreign ntry)
		L	Usual Residence of Decedent	Jan. 1,		land
	/larylan 8a-f sh tified a	Director	Maryland Montgomery Silver Spring			10d. Inside City Limits 1 ☐ Yes 2 💢 No
	th the N 3a or 2 t be no			10	og. Citizen of What Cou United St	
	eath wi	Funeral	1121 University Blvd., W. #104 20902 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces If Yes, specify Cuban, Mexican, Mexican,	in? (Specify Yes or No-	14. Race - Ameri	
36	after de	by	1 Never Married 2 M Married 1 Never Married 2 No Married 1 No No	, Puerto Rican, etc.)	Black, White,	
2-00	hours natura lical E	letec	3 Widowed 4 Divorced Pear or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation		6b. Kind of Business/Ir	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Owner	of working	Variety	,
nd 2	filed wall Hygind of other	Be	17. Father's Name (First, Middle, Last) 18. Mother	r's Name (First, Middle, Ma	aiden Surname)	
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Ma	d 2 sho alth an 1 27 is a		19a. Informant's Name/Relationship (Type, Print) Mendel Rozmaryn, Husband 19b. Mailing Address (Street and Number 1121 University Blvd)	r or Rural Route Number, C d., W., #401	City or Town, State, Zip . , Silver S	pring, MD
lore,	ge 1 an it of He If item or othe		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 X Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)			whashington.
Itim	artmer artmer ortant injury				lew Jersey	
ä	Dep Imp any	1	MOIDON 254 Carroll St.			20012
			23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as c shock, or heart failure. List only one cause on each line. Immediate Cause (Final	cardiac or respiratory arres	t,	Approximate Interval Between Onset and Death
~~. <u> </u>	Medical		disease or condition resulting in death) Alzheimers Disease Due to (or as a consequence of):		-	years
	Examiner	je je	Sequentially list conditions, b.			
_	po D	amin	if any, leading to immediate Due to (or as a consequence of): Cause (Disease or injury			
	ite be executed hysician and the burial tracki	dical Examine	that initiated events resulting in death) Last Due to (or as a consequence of):			
760	icate b	ledic	d			
Box 687	eath certifica attending p	ian/N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1		23d. Date of deliv	
. Bo	The law requires that the death certifica ate has been signed by the attending plage 2 should be detached for use as to	Physician/Me	1 ☐ Yes 2 X No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		Month	Day Year
. P.O.	requires that the des been signed by the s should be detached	by	Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.		cco use contribute to t	
Division of Vital Records,	require been s should	leted		1 Ll Yes	24h Were auto	bably 4 Ll Unknown ppsy findings available
Rec	The law ate has page 2	Completed		autopsy perform	prior to co ed? death?	mpletion of cause of
ta	nysician: The lav nis certificate has I director, page 2	Be	25. Was case referred to medical examiner? Hospital: 26. Place of Death	(Check only one)		
of V	rding Phys th. After this funeral di	te: To	27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at	rsing Home 5 🕅 Residen 28d. Describe how		/)
ion	uttendin death. ctor: Aff y the fu	Certificate:	2 Accident Investigation M 1 Yes 2 N 3 Suicide 6 Could not be			
Divis	al or Attend s after death il Director: A ed in by the f		4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stre City or Town,	et and Number or Rura State)	l Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completely filled in by the funeral director.	Medical	29a. Certifier (Check 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and processing the control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and processing the control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and processing the control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and processing the control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and processing the control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and processing the control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and processing the control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and processing the control of the basis of examination and/or investigation, in my opinion, death occurred at the control of the cont	curred at the time, date and	place, and due to the ca	use(s) and manner stated.
	To the within To the Comple	Ž	only one) 3 La Certifying Nurse Practitions. To the best of my knowledge, death occurred at the time, date 29b. Signature and title of certifier 29c. License number		d. Date signed (Month,	
D	5		Ishl Rose been D09824		November 1	4, 2012
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barry N. Rosenbaum, MD, 3720 Farragut Ave., Kensir	ngton, MD 2	0895-2110	
	Stat	_	31. Date filed (Month, Day, Year) 32 Registrar's Signature			
	Registra	ir	NOV 19 2012 Come B. Sarces.			

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 40881 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month un ber 15:37 P M Medical Facility Name (if not institution, give street and number 4b. City, Town, or Location of Dear Examiner 4c. County of Death ohns If Under 1 Year Social Security Number 6. Sex If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 579-19-1258 Months Davs Hours Min. Director 1 □ M 2 🏝 F Yrs. 66 Sept. 5, 1946 Dominican Republic Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumati event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State 1 Yes 2 No DC Washington ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 735 Quebec Place, NW, Apt. 2 20010 Dominican Republic Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces permit. Page 1 and 2 should e filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is maried other than "natural", or I any injury or other traumatic event, the Medical Examina once. Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes 241X No Yes, Give Baltimore, Maryland 21215-0036 x⊠yes 2□no specify:Dominican Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Contractor Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Andres Martinez Ozema Rivera 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia A. Tejeda Rivera/Daughter 1806 Blueridge Ave., Silver Spring, MD 20902 Date 24, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☒ Removal from State Nov. Santo Domingo, Cementerio Nacional 4 Donation 5 Other (Specify) 2012 Dominican Republic 21. Signature of Funeral Service Licenses Francis Adjess Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Inter the disease, or complications that contain the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ NECROTIZING FASCIITIS disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner CELL LYMPHOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) ng physician and se as the burial-transit law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) ed by the a 9 Unknown 9 Unknown P.O. To the Hospital or Attending Physician: The law requires that within 24 hours after death.

To the Funeral Director: After this certificate has been signed to applicately filled in by the funeral director; page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 12 No Attending Physician: The 2 🗆 No 1 Tyes 25. Was case referred to medical of Vital æ 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Tes 2 🔀 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Division 2 Accident 1 Yes 2 No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗍 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause 29b. Signature and title of certifie DDC MP Acrus 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1800 orleans Stree MONIQUE JAMES, MD

Registrar

State

31. Date filed (Month, Day, Year)

NOV 19

2012

32/Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 40882 Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 2012 4:35 P M George Hammond Rever Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Homewood at Williamsport Williamsport Washington Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Months Hours 216-28-3809 Director 1 🛛 M 2 🗆 F 88 July 11,1924 Maryland 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.
27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16505 Virginia Ave. 21795 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☑ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married ۶ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 XWidowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry grade completed) (Specify only highest (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 th +4 Secretary Rail Road æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George W. Rever Marcella A. Weaver and 2 should the Health and Me Item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2827 Cub Hill Road, Parkville, MD 21234 Robert McKenny / Cousin or other item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any Injury or ot 20c. Location - City or Town, State 1 Burial Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematorium 12/4/2012 Smithsburg, MD 21. Signature of Euneral Service License 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac St., Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on -act line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause Fr.
Cause (Disease or injury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and hompletely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death Physician/ Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 9 Unknown 5 Other (specify) Month Day Year Yes 2 No 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Other: ဂ္ဂ 1 TYes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗋 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

DHMH 17 Rev 06-2011

29b. Signature

evil

6806

Coulifying Nurse Practitioner: To the best of my knowledge

completed cause of death (Item 23a) (Type, Print) 15

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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imore Page 1 a	0 1		20a. Method of Disposition 1	Removal from	State		natory or other plac		Date	1	20c. Location	-		
Baltimore, permit. Page 1 and	Department Important; I any injury or once.	30	4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Lice		MiT		RY UAME C		12/10				MARYLAND	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland /	Depa		t of H	lealth a				112	40884
	Dhusisia	/	Registrar 1. Decedent's Name (First, Middle, Last)						2. Date of De	ath		3. Time of Death
	Physicia Medic	al	Vernon E.	Sch	lotzh				Noveml	per 30,		17:24 PM
	Examin	er	4a. Facility Name (if not institution, give street and number)			rown, or	Location of	f Death		4c. Count	y of Death	
	Funeral		Union Hospita1 5. Social Security Number 6. Sex 7. Age (In yrs. last bi				If Under 2	4 Hrs. Min.	8. Date of Birt	th	1	lace (State or Foreign
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<u><u>E</u></u>	Page ment c ant: If ury or		1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State cemet 4 ☐ Donation 5 ☐ Other (Specify) Phila	-	natory or ot ohia (1.14	ecemb 20	er 5, 12	Philadel	phia, F	PA
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if flem 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signal re of Funeral Service Licensee	-			s of Facility ckton		cks Hom , Elkto		Tunera 21921	als, P.A.
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3+	,		30. Name and address of person who completed cause of death (Item 23a) Sason Matthews 106 Bow St	(Type, P	rint) Elktor	1/1	10, 2	219	21			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Regina V. Sweeney November 2012 3:20a Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7043 Blue Mountain Road Thurmont Frederick Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🔀 F Days Min. (Month Day, Year) Months Hours Maryland May **Director** 215-26-8608 81 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 🗌 Yes 2 🔀 No Frederick Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7043 Blue Mountain Road 21788 United States hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🕱 No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give "natural", Specify: 3 → Widowed 4 □ Divorced Completed Year or Dates White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Guy Franklin Martin Mary Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau David Sweeney / Son 7043 Blue Mountain Road, Thurmont, MD 21788 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 👿 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Prospect Cemetery 11/30/2012 Lewistown, Maryland. 21. Signatur uneral S 22. Name and Address of Facility
Stauffer Funeral Homes P. A.
1621 Opossumtown Pike, Frederick, Maryland 21788 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death BRENST ('ANCER Immediate Cause (Final METASTARC Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed and-trar that initiated events resulting in death) Last Due to (or as a consequence of) anding physician a use as the burial-Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
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5 Other (specify) atter for u in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Pregnant at time of death g 🗌 Unknown the hed P.O. ed by t detach signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 1 🗌 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 1 X Natural 5 Pending To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu death. 1 Yes 2 No Investigation 6 Could not be 2 Accident
3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 00035152

Registrar DHMH 17 Rev 7/2009

3

State

31. Date filed (Month

MO

100

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.0

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Michael Hale Sisson November 26 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick 8. Date of Birth (Month, Day, Year) Dec • 28, 1 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country)

Texas 7. Age (In yrs. last birthday) Funeral 554-97-0588 Director 1 M 2 □ F 31 1980 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Middletown 1 🗆 Yes 2 🕅 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral 6527 Morningside Court 21769 United States Paga 1 end 2 should be filad within 72 hours after death nent of Health and Mantal Hygiena. . Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White 3 Divorced Year or Dates. 2002-2004 Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Information Technologist Computers Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Sisson Dinah Perrv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Sisson / Father 6527 Morningside Court, Middletown, Maryland 21769 Place of Disposition (Name of cemetery, crematory or other place)
 John's Cemetery 20a. Method of Disposition 20c. Location - City or Town, State parmit. Paga 1
Department of I
Importent: If it
any injury or of November 30 1 M Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 <u>Frederick, Maryland</u> 21. Signaty e of Funeral Service Licensee Keeney and Basiford PA Funeral Home 106 E. Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. Unit only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consumence of): Examiner 7ac MON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Dissase or injury that initiated events Examine Due to (or as a consequence of To the Hospital or Attending Physician: The lew requires thet tha death certificate be axecuted within 24 hours after death.

To the Funeral Director: After this certificate has bean signed by the etlanding physician and completaly filled in by the funeral director, page 2 should be detached for use as tha burlal-transit resulting in death) Last Due to (or as a consequer) To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 After this certificate hes bean signed by the ettanding funeral director, page 2 should be detached for use es yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time and IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 200 Nopatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Alatural 2 Accident Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes 2 🗌 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) at Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check lical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one 29b. Signature MDD 65378 of Aerson who completed cause of death (Item 23a) (Type, Print)

20 State

31. Date filed (Month, Da

Year) 9 2012

Registrar

DHMH 17 Rev 06-2011

Cika

L

egistrar's Signature

400 W. Seventh Street, Frederick, Maryland 21701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 23 2012 5:43pm Jennifer Sappington Dawn Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Frederick Frederick Frederick Memorial Hospital If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Director 220-82-5357 1 □ M 2 🗓 F 07/28/1975 Maryland 28a-f shov 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.
27 is marked other then "natural", or items 23a or 28a-f shor traumetic event, the Medical Exactions to such be mortified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8118 Broadview Drive 21701-3204 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. δ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be file of Health and Mental H I Item 27 is marked o ည Richard Sappington Susan Joy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and.
Department of Healt
Important: If Item 27
any injury or other tr.
ange. 8118 Broadview Dr., Frederick, MD 21701-3204 Richard Sappington/ father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mary's Cemetery 11-29-2012 Knoxville, MD 22. Name and Address of Facility Stauffer Funeral Homes, P.A. Signature of Funeral Service Licensee 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) years Medical Due to for as a consequence of): Examiner hronic Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): attending physicien and for use as the burlal-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 🗓 No Month Dav Year To the Hospital or Attending Physician: The law requires that the dea within 24 hours after deeth.
To the Funeral Director: After this certificete has been signed by the a completely filled in by the funeral director, page 2 should be detached to P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) 8 examiner? 1 ☐ Yes 2 🔀 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 I DOA ၉ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending Division 1 Yes 2 No Accident М Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21703

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend #5 Per FH JM 11/2**9¢rtit**cate of Death 1. Decedent's Name, (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 11\55\507\507\500 KUBIN Simms 04:25 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince Georges Clinton Nursing Rehab Center Clinton 5. Social Security Namber If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** 578-70-5257 Director 1 🗆 M 2 🗶 F 60 12/28/1951 DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits notified at Funeral Director 28a-f 1 X Yes 2 No MD Prince Georges Temple Hills 10e. Street and Number 10g. Citizen of What Country? must be 23a **AZU** 20748 5411 Winston St. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. Specify: Black Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry th and Mental Hygiene.
27 is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) LPN Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lorraine Ford Unknown ge 1 and 2 should but of Health and Merel item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1601 Hollindale Dr., Alexandria, VA 22306 Barry L. Ford / brother 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State St. Catherine Cem. ò permit. Page Department o Important: If any injury or 75/07/5075 Port Tobacco, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Strickland Funeral Services 21. Signature of Funeral Service 6500 Allentown Rd., Camp Springs, MD 20748 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 1. Enter the disease. shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ DemenTia Medical resulting in death) **Examiner** Disecse 5 Toy 8 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Trilure 10 Thrive Due to (or as a consequence of) resulting in death) Last signed by the attending physician d be detached for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant Month Dav Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) completely filled in by the funeral 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: After X Natural injury 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 11/26/12 Glen Burnie, MD

15 JM

Registrar

DHMH 17 Rev 06-2011

13/00 \mathbb{Z}

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 40889 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ CH:25AM IRREL Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Bennington arlbore Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) 9-76-9053 Hours Min. Director 1 M 2 - F MSSHIMICED DC show ∩a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland notified at Director Iaru 28a-f 1 Nes 2 □ No 9 10e. Street and Number 10f. Zip Code ms 23a or Bennington Funeral items Was Decedent Ever in U.S. Armed Forces?/ 1 ☐ Yes 2 ☐ No If Yes. Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, an "natural", or iter Medical Examiner Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 If Yes, Give Year or Dates. filed within 72 hours after 3 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 219 Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working nt of Health and Mental Hygiene.

t: If item 27 is marked other than ite. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) abor Be Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Warren SMIDN VONHE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type, Drive upperMan born MD Smith 11518 BENNINGTON Warshielle wife Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Herutage McWorual 12-5-2012 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Department of Important: If any injury or once. Waldon WISEMAN FUNERAL Home 22. Name and Address of Facility old Hexendris Formy Roldinter MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Colon Onset and Death Immediate Cause (Final ancer Physician/ Tasta'T7C disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, it any leading to in rediate cause. Enter Underlying Due to (or as a consequence of) Examir burial-transit Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician I for use as the buris Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 cate has by page 2 s within 24 hours after death.

To the Funeral Director: After this certificate 2 No 1 Yes 25. Was case referred to medical Hospital or Attending Physician: filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 ☑ No Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number aunt 14 20058213

State

DHMH 17 Rev 06-2011

Registrar

30. Name and address of

FARHAD

DEC

ORIGINAL

12150 Aunapolis

erson who completed cause of death (Item 23a) (Type, Print)

Registrar's Signa

MD

MAL

Rd Giem Dale MD 22769

			For State Registrar		State of	Marylan		artment c rtificate			Mental Hy	gien Reg. N	71117	408	90
		51	Decedent's Nam	ne (First, Middle, I	Last)						2. Date of D	eath		3. Time of De	ath
E	Physici /Medio		Robert	James	Schied						Nov. I		2012 Year		3. M
T.	Examir	er		'If not institution, g acefield	rive street and num Road	ber)		3.		cation of Deatl Spring	1	4	c. County of Dea	ath	
	Funeral Director		5. Social Security 1 094–16–3	Number 6		7. Age (In yrs. I		If Under 1 Y	ear If	Under 24 Hrs. lours Min.	8. Date of Bi (Month, D	ay, Year	r) C	rthplace (State or Fountry)	oreign
	and w		Usual Residence of	of Decedent 10b. County		10c. City	/. Town or Lo	cation						10d. Inside City L	imits
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	th with the 23a or 28a ist be noti	al Director	10e. Street and Nu 3152 Gr	umber cacefield	l Road			10f. Zip Co	^{de} 904			10g. C	itizen of What C	ountry?	
336	be filed within 72 hours after death with the Maryland that Hyglene. dother than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Mar 3 ☐ Widowed	ried 2⊠ Married	If Von Cive	ces? 2 □ No		Was Decedent If Yes, specify 1 ☐ Yes 2 🛱		anic Origin? (S Mexican, Puerl Specify:	pecify Yes or N o Rican, etc.)	0-	14. Race - Am Black, Wh Specify: Wh	ite, etc.	
21215-0036	in 72 hou n "natura Medical E	Completed		15. Decedent's acify only highest g	Education grade completed)		16a Dece	ient's Usual O kind of work d DO NOT use re	ccupatio one durii etired)	n ng most of wo	rking	16b.	I Kind of Busines	s/Industry	
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Maryland	should be filed vand Mental Hygies marked other tumatic event, th	To Be (17. Father's Name	(First, Middle, La	st)				18		ne <i>(First, Middle</i> eth Fis		ŕ		
Man	12 ha		19a. Informant's N James P.	lame/Relationship Ewing/N	(Type. Print) Nephew								or Town, State,	• /	
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Baltimore,	permit. Pages of Department of Himportant: If ite any Injury or of once.			5 ☐ Other (Spe	cify)			an Crei		ry	2012		exandri ome Inc.	a, VA	
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68760,	ficate be executed physician and is the burtansit		that initiated event resulting in death)	Last	CDue to (a	r as a consequ	uence of);								
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Division or Vital Records,	: The law requir cate has been si page 2 should I	Completed by									24a. Wa: auto peri 1□ Yes	s an opsy formed? 2 DK	prior to death?		ailable se of
Vita	Physician: The this certificate ral director, pag	Be C	25. Was case refe examiner?	rred to medical	Hannitale					6. Place of Dea	ath (Check only				
Or	Physical this care direction	- T	1 ☐ Yes 2 ☐ 27. Manner of Dea		Hospital: 1 ☐ In		ER/Outpatier 28b. Time o				fome 5 ☑ Res 28d. Describe		6 □Other (Sp	ecify)	
ion	Attending r death. ector: After by the fune	ation	1 ☑ Natural 2 ☐ Accident	5 ☐ Pending investigat	(Month	n, Day Year)	Injury	М	Injury at Work? 1 ☐ Yes	2 □ No		,	,		
Divis	at or Atte after des I Directo	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not determine	d Zee. Place	of injury - At ho g, etc. (Specify	ome, farm, str	eet, factory, of	fice		28f. Location City or To			Rural Route Numbe	r,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier (Check only one)		Physician: To the laminer: On the ba	sis of examinat									
	To the within 2 To the complet	Me	29b. Signature and	d title of certifier	1/0			l	cense nu			29d. D	ate signed (Moi		
	10+1) C	the	Ksna	eir		D	5/	284			Nov	1620	12
_			Ana Korz	an, MD	3160 Gr	acefiel	d Road	, Silv	er S	pring,	MD 209	04			
	Sta Registr		31. Date filed (Mod	nth, Day, Year)	012	gistrar's Signa	1. 400	Med.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedentis Name (First, Middle, Last) 2 Date of Death Physician/ ene December 3, 2012 1:33P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8952 Hawbottom Road Frederick Middletown 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country PA 204-30-8601 Months Davs Hours August 21, Director 192 1 X M 2 □ F 83 Yrs Usual Residence of Decedent i Hygiene. Jother then "neture!", or Items 23e or 28e-f ehow vent, Ite Medicel Examiner must be motified at 10b. Count 10c. City. Town or Location 10d. Inside City Limits Direct Middletown 1 X Yes 2 ☐ No Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21769 U.S.A. 8952 Hawbottom Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 ☐XNo Specify: Completed 3 Widowed 4 Divorced Specify: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Distributor Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Catharine May Gruver should be flie end Mentel F le marked of permit. Page 1 and 2 should be)
Department of Heeith and Mentel importent: if item 27 is mediany or other? Milton Heffner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8952 Hawbottom Road, Middletown, MD Janet L. Stegner/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 KBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bendersville Cemetery 12/08/2012 Bendersville, PA 21. Signatur - Ed. - Berne Licensee 22. Name and Address of Facility Dugan Funeral Home, Inc. 111 S. Main Street, Bendersville, PA or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician MULTIDIE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): ettending physicien end I for use es the buriei-trensit To the Hoepitel or Attending Physician: The iew requires that tha deeth certificete be executed within 24 hours effer death. Within 24 hours effer death. To the Funeral Director: After this certificete has bean signed by the ettending physicien end completely filled in by the funerel director, page 2 should be deteched for use as the buriel-transit Cause (Disease or i that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Distar - myocandial CORONARY ARTSMY 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an yes 2 No 1 ☐ Yes 2 ☐ No å 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12-4-2012

State Registrar

IW-15+1

AUG

NINTH

BRUNSWICK, MD 2 1716

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

60

32. Registrar's Signature

KINCAND MD

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State	State of M	laryland / Depa	artment of h	Health and	Mental Hy	giene ₂₀	12	40892	
	Registrar 1. Decedent's Name (First, Middle, Last)				Certificate of Death			Reg. No.			
Physicia	Physician/						Month	2. Date of Death Month Day Yes November 30, 30		3. Time of Death	
Medi		Robert 4a. Facility Name (if not institution,	Lashley		ott	r Location of Deatl	Novem	ser 30,	2013	1:05 AM	
Exami	ner	Meritus Medica	-		Hagers		1	4c. County	y of Death hingt	an.	
Funeral				ge (In yrs. last birthday)	If Under 1 Year		8. Date of Bir			JII lace (State or Foreign	
Director		215-20-9021	1 X M 2 □ F	92 Yrs.	Months Days	Hours Min.	(Month, Da	y, Year)	Count	ny)	
M	1	Usual Residence of Decedent					Apr. 13	3, 1920		land	
yland f sho sd at	햕	10a. State 10b. County		10c. City, Town or Lo	cation				11	0d. Inside City Limits	
Mar 28a- notifie	ie	Maryland Washington Hagerstown								1 🛚 Yes 2 🗌 No	
th the	를	10e. Street and Number 10f. Zip Code 21742						10g. Citizen of U.S.A.	What Coun	try?	
ms 2 musi	Funeral Director	18715 Preston		as Decedent of Hispanic Origin? (Specify Yes or No-							
r dea	J.F.	11. Marital Status 1 □ Never Married 2 ☒ Marr	12. Was Decedent Armed Forces?	?	Vas Decedent of H f Yes, spe <mark>c</mark> ify Cuba	lispanic Origin? (Sp an, Mexican, Puert	oecify Yes or No- o Rican, etc.)		ce - America ck, White, e		
al", o	d by	3 Widowed 4 Divorced	ied 1 X Yes 2 If Yes, Give Year or Dates.	No .	Yes 2 🛚 No	Specify:		Specify	Whi	te	
Z I Z I 3-0030 within 72 hours after glene. er than "natural", o the Medical Exam	Completed	15. Deceder	t's Education	lent's Usual Occup		16b. Kind of Business/Industry		ustry			
7 3 n 72 an "r Med	m	(Specify only highest grade completed) (Give kind of work done during most life, DO NOT use retired)					king				
withii giene er th		Elementary/occorridary (o 12)	2	A:	ircraft I	nspector		Avia	tion		
yland Id be filed Mental Hy arked oth	o Be	17. Father's Name (First, Middle, L	ast)			18. Mother's Nar	me (First, Middle,	Maiden Surnam	e)		
Vicinity Ment	은	Albert L. Scot	t, Sr.			He1en	n L. Lashley				
Mar 2 shou th and 27 is m traum	16	19a. Informant's Name/Relationsh	ip (Type, Print)	19b. Mailir	ng Address (Street	and Number or Ru	ral Route Numbe	r, City or Town, S	State, Zip C	ode)	
tind 2 lealth lealth im 27 her tu		Suzanne Sigler	Step Daugh		nris Driv	e, Marti	nsburg,				
or oth		20a. Method of Disposition 1 X Burial 2 Cremation	3 A Removal from State	20b. Place of Dispo cemetery, cren	sition (Name of natory or other plac		Date	20c. Location	,		
Dallinore, Permit. Page 1 and Pepartment of Hee mportant: If item ny injury or othe		4 Donation 5 Other (S		Rest Have		ry 12/0	03/2012	Hagers	town,	Maryland	
Datuillore, IMaryliand ZIZIO-UU30 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service L	Сольее		. Name and Addres					- 1	
		220 Part 1 Enter the diagram or	Sup	I16	01 Penns	ylvania <i>i</i>	Avenue	<u>Hagerst</u>	own M		
		23a. Part 1. Enter the disease, or shock, or heart failure. List o Immediate Cause (Final	nly one cause on each lin	ne.	er the mode of dyin	g, such as caldiac	or respiratory arr	651,		Approximate Interval Between Onset and Death	
Physician/Medical		disease or condition								Onlock and Boath	
Medical resulting in death) Due to (or as a consequence of):										i	
€.	je.	Sequentially list conditions, if any, leading to immediate									
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iffication of physical as the	Med	IF FEMALE:									
n certifica tending p	an/l	23b. Was decedent pregnant	23c. If yes, outcome	e of pregnancy 2 Fetal death 3	Ectopic pregnanc	EV.		23d. Da	te of delive	У	
death he atte	Physician/Me	in the past 12 mooths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Other (specify)	her (specify)			Month Day Year				
s that the dea igned by the a be detached the	Phy		as contributing to death	but not resulting in the u	nderlying cause div	en in Part I	220 Did to	hanna una cont	ributo to th	a server of death?	
J, F, F, Iires the signed Id be d	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributions to the conditions contributing to death but not resulting in the underlying cause given in Part I.									
require been si	etec	2010 1 0101						1 Yes 2 No 3 Probably 4 Honknown			
law r has t	Completed	Dinseres Mellips						24a. Was an autopsy prior to completion of cause o death?			
r: The icate										2 🗆 No	
ysician: s certific director,	Be (25. Was case referred to incal examiner? 1 Yes 2 No Hospital: Theoretical: 2 DOA Other: Doad Other: Ot									
Phys r this eral d	e: To	27. Manner of Death	28a. Date of inju	tient 2 ER/Outpatien ury 28b. Time of	t 3 L DOA 28c. Injury	4 ☐ Nursing H	ome 5 Resid	lence 6 L Othe ow injury occurr			
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I or Attendii after death. Director: Ai d in by the fu	Certificate:	3 Suicide 6 Could r	ot be 28e. Place of Inj	jury - At home, farm, stre			28f. Location (S	treet and Numb	er or Rural I	Route Number,	
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affect eath. To the Funeral Director, Affer this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
the H hin 24 the F		(Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
punile Anecesta HOO61117 Novem							29d. Date signed (Month, Day, Year)			ay, Year)	
							Ber	er 30, 2012			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)									ا		
-01-		31. Date filed (Month, Day, Year)	Dane	rar's Signature	VICTO IV.	1000	~ Cax	(-61)			
Star Registra		DEC 0.5	285 7 2 A	ar s Signature	A.A.J						
	-		- F	11377							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 40893 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ WILMA E. SERMAN November Medical 2012 4:45 P 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hartley Hall Care Center Pocomoke City Worcester If Under 1 Year If Under 24 Hrs Social Security Number Funeral 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours Director 377-34-2459 1 □ M 2 🖫 F 78 09/16/1934 Michigan Usual Residence of Decedent within 72 hours after death with the Maryland an "natural", or Items 23a or 28a-f sho We diest Examinar must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Somerset Crisfield 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 26630 Crackertown Road 21817 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No 1 ☐ Yes 2 ☑ No Specify: White 3X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coilege (1-4 or 5+) the Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental I permit, Page 1 and 2 should be file Department of Health and Mental Important: If Item 27 ia marked c any Injury or other treumatic eve Marvin J. Northrop Pearl Grim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter Jay Heavenridge (Son) 26630 Crackertown Road - Crisfield, MD 21817 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Crematory of Delmarva 12/01/2012 Delmar, DE 4 Donation 5 Other (Specify) 21. Signature of Fundal Service Licenses

Robert H. Bradshaw, 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME Main St. - Crisfield, Maryland 306 W. 21817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician ARKINSON'S SEAJE disease or condition resulting in death) Medical Due to (or as a consequence of): ¹Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) 4 Pregnant a Pregnant at time of death Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗖 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 2 No 1 Yes Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 2| 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, Cify or Town, State) determined edical 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **D **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 **D **Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11-26-2012. 62172 lu () 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1604 MARKET ST. POCOMOKE CITY SATYAL MD 21851 R MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 2 8 2012

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 40894 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1^{Month} 20 Betty Ann Smith 2012 19:30 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Carroll Hospital Center Westminster 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 577-56-1878 **Director** 71 1 M 2 XF 06/30/1941 Washington, D.C 2 should be filed within 72 hours after death with the Maryland than Mantal Hygiene.
Ith and Mantal Hygiene.
Its marked other then "natural", or items 23a or 28e-f show the warmaft awant, the Market Engline or than the market that the market than the market than the market than the market that the mar 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Carroll MD Taneytown 1 Tyes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 304 Huntinghorn St. 21787 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black White etc. 1 Never Married 2 Married Completed by 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Human Resources Director H.U.D. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Unknown Elizabeth Novak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jayme Burdette/granddaughter f Health itam 27 45 E. Second St., Waynesboro, PA parmit. Paga 1 and 2 Department of Health Importent: If itam 27 eny Injury or othar tr once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place Carroll Cremation 11/23/2012 Hampstead, MD 21074 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address Protects Funeral Home and Chapel, PA h V 412 Washington Road, Westminster, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ orona disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Diabet Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami attending physician and for use as the burial-transit that the death certificate be executed Due to (or as a consequence of resulting in death) Last Physician/Medical ibl 55 Stomac Box 68760 IF FEMALE: IF FEMALE:
23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy 4 Pregnant a 9 Unknown Pregnant at time of death 5 Other (specify) Month Dav Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attanding Physician: The lew requires within 24 hours after death.

To the Funarel Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٥ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined cal 29a. Certifier 1 (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To tha within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Melance 11/21 NILAR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Washington Rd stmenster 31. Date filed (Month, Day, Year) NOV 2 6 2012 State 32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 29 Day 2012 Year NOV. David Hanford Stephenson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis Anne Arundel Anne Arundel Medical Center Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Director 130-28-9909 1 X M 2 □ F 76 09/07/1936 Usual Residence of Decedent show i Hygiene. I other than "natural", or items 23a or 28a-f shov vent, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21401 USA 199 Prince George Street 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Professor Education æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o ဥ Elizabeth Hastings Robert P. Stephenson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 199 Prince George St. Annapolis, MD 21401 Helen Stephenson (wife) Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury or 11/30/2012 Glen Burnie, MD Atlantic Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home 9.0 78 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ metastasis Scain disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner NState Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Inneral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 Yes 2 No g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Completed 1 Yes 2 No 3 Probably 4 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ဂ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending iniury 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 29a. Certifier Lecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

Medical Rexuly # 212, Amagodis, MD 2140/

Unknown

1 X Yes 2 ☐ No

NY

10:50 A M

State Registrar

DHMH 17 Rev 06-2011

anine

NOV 3 0 2012

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Tori Danielle Sti	•	State of Maryland / Department of Health and Mental H							
-		1- For State Registrar 1. Decedent's Name (First, Middle, Last)		No. 2012 40896					
Physician/ Medical Examiner		Tori Danielle Stitely	Date of Death Month November 2	Day Year 0430 hrs					
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death University Hospital Baltimore	4c. County of Death						
Funeral Director		$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$		(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Maryland					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Important: If titem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	leted by Funeral Director	Usual Residence of Decedent 10a. State Maryland Anne Arundel 10b. County Maryland Anne Arundel 10c. City, Town or Location Annapolis 10d. City, Town or Location Annapolis 10d. City, Town or Location Annapolis 10d. Zip Code 21401 11. Marital Status 12. Was Decedent Ever in U.S. 1	pecify Yes or No- Rican, etc.)	10d. Inside City Limits 1 X yes 2 No 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Dept. of Defense					
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	To Be Completed	17. Father's Name (First, Middle, Last) 18.Mother's Name	18.Mother's Name (First, Middle, M. Tawny L. Wilson						
MD 21; d 2 should b Ith and Men 1.7 is mar numatic eve		19a. Informant's Name/Relationship (Type, Print) Kevin Stitely/father 19b. Mailing Address (Street and Number or F 53 Cornhill Street	Rural Route Numb Annapolis	er, City or Town, State, Zip Code) S. Maryland 21401					
Baltimore, cernit. Pages and Department of Heal Important: If iten		21. Signature of Fune all Service Licensee 22. Name and Address of Facility Jo	/1/2012 hn M. Tay	20c. Location - City or Town, State Annapolis, Maryland ylor Funeral Home					
Physician	-1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of	ster St., or respiratory arres	Annapolis, MD 21401					
/Medical xaminer	Examiner	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or highry that initiated events resulting in death) Last Between Code Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):							
0 8 7	Physician/Medical	UNPENDED AMENDED							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the finneral director, page 2 should be detached for use as the buril.		23b. Was decedent pregnant in the past 12 months? 1	ancy	23d. Date of delivery Month Day Year					
IS, P.O. quires that then signed by all be detach	Š	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1 Yes	acco use contribute to the cause of death? 2 No 3 Probably 4 Unknown					
Record The law rec ficate has bee	Completed		24a. Was an autopsy perform	prior to completion of cause of death?					
i of Vital Recing Physician: The After this certificate uneral director, page	To Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No 1. ✓ Yes 2 No 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	ng Home 5 Re	esidence 6 Other:					
Division of Vital Records, To the Hospital or Attending Physician: The law require within 24 hours after death. To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should be	Certification:	1 Natural 5 Pending Investigation 2 Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, or Town State)							
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	ical Cert	4 Homicide determined (Specify) Major Road / Highway 1144 Annapolis Road, Odenton, MD 29a. Certiffer (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
To t with To t comp	Medical	29b. Signature and title of certifier 29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) November 27, 2012					
4,6		 Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 900 W. Baltimore Street, B 	Baltimore, MD	21223					
St Regist	ate rar	31. Date filed (Month, Day, Year) 9 2012 32. Registrar's Signature 4.							

Mr. L

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene = State Registrar 40897 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day, Physician/ December 2012 10:53 p M Chrest James Seymour Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 200 Bezold Ave Carroll Westminster 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Min (Month, Day, Year) 231-44-2776 **Director** 1 **x** M 2 □ F 74 July 23, 1938 Virginia 28a-f show 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director notified Carroll Westminster MD 1 Tes 2 X No 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? pe Funeral er than "natural", or items 23, the Medical Examiner must 200 Bezold Ave. 21157 USA permit. Page 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2X Married 1 Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 2 No11/10/76 1 Yes 2 No Specify Specify Completed 3 Divorced 4 Divorced White 06/30/79 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the N Master Sergeant U.S. Air Force Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ Vernon Seymour Elizabeth Chrest 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Chrest-Seymour, wife 200 Bezold Ave. Westminster, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Inc 12/10/12 Hampstead, Maryland 21. Signature of Foneral Service Licensee 22. Name and Address of Facilit Pritts Funeral Home & Chapel, PA 412 Washington Rd. Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_{sician} 6 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to humediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami use as the burial-transi and Due to (or as a consequence of): attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death
Unknown been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? Yes 2 No 24 hours a 'er dea'h. • Funeral Director: After this certificate l 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 1 Yes မ 4 🗌 Nursing Home 1 Inpatient 2 I ER/Outpatient 3 I DOA 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check within 2. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item 5 per 1h g936 2-25-13 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month DECEMBER MARY FRANCES TAYLOR 10:15 P^M 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4147 GRAVEL HILL ROAD HAVRE DE GRACE HARFORD 5. Social Security Number 6556 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Hours Country) Director 1 □ M 2 🕅 F 73 JAN 01, 1939 MARYLAND Usual Residence of Dece th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified at</u> 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No MARYLAND HARFORD HAVRE DE GRACE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4147 GRAVEL HILL ROAD 21078 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married ģ ☐ Yes 2 X No 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: BLACK 3 X Widowed 4 ☐ Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be f Health and Mental Hy item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ WILLIAM DURBIN ANNIE MARY CROXSELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELIZABETH R. TAYLOR / DAUGHTER 4147 GRAVEL HILL ROAD, HAVRE DE GRACE, MD 21078 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of Important: If it any injury or of once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ST JAMES/ GRAVEL HILL 12/8/12 HAVRE DE GRACE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
LISA SCOTT FUNERAL HOME,
552 LEWIS STREET, HAVRE MD_21078 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Dire to for as a consequence off or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical 14 Y L O R Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 Ø No
9 ☐ Unknown 5 Other (specify) Month Day 9 Unknown completely filled in by the funeral director, page 2 should be detact Part II. **Other** s<mark>ignificant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 🕽 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation within 24 hours after dear To the Funeral Director: 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature an 29d. Date signed (Month, Day, Year) 5 who completed cause of death (Item 23a) (Type, Print) VD State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend #1, per phy, 10b-c, 10e-f, per fh, g939 5-10-13 sm
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Linda Ann Taylor Linda Anne Taylor Physician/ 2012 8:08 P MNovember Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) Days Hours 219-64-0780 Director 1 🗆 M 2 🖾 F 58 June 20, 1954 Cheverly, Maryland show or 28a-f shov notified at 10a. State Prince George's 10c. City, Town or Location

Riverdale

Potomac Director Maryland Montgomery 1 X Yes 2 No 10e. Street and Number 5908 61st Avenue 10f. Zip Code **20737** items 23a or ner must be n 10g. Citizen of What Country? Funeral 11816 Enid Drive 20854 USA within 72 hours after death ural", or item | Examiner r 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", 3 - Widowed 4 - Divorced Specify: White Completed Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ene. Elementary/Secondary (0-12) College (1-4 or 5+) Retail Retail Associate nd Mental Hygiens marked other th 12 other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည should be James Earl Beach Clare Ann Jasinski off. Page 1 and 2 shours out of Health and Mr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrea K. Beach / Sister 1143 Simsbury Court, Crofton, MD 21114 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 12/3/2012 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, Virginia Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 FAM Roses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Atherosclerotic Cardiovascular Disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No Month Day Vear 1 Yes 2 2 9 Unknown signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Morbid Obesity Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 Yes 2 No Yes il or Attending Physician; after death.
Director, After this certifica 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 🔀 No မ 1 Inpatient 2 X ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28h. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗵 Natural 5 Pending work' 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) and title of certifier 29d. Date signed (Month, Day, Year) D31027 11/30/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ্বর Paul D. O'Brien, M.D. 8600 Old Georgetown Road, Bethesda, MD 20814 31. Date filed (Me Registrar's Signato State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State
Registra MEND#19b+20bperFH, 12/5/12; BMW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Leona A. Turner \mathbf{P}^{M} <u>November</u> 22,2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Fort Washington Health and Rehab Fort Washington Prince George's 8. Date of Birth (Month, Day, Y 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Director 92 Dec. 058-28-0795 New York Usual Residence of Decedent 10a. State 10b. County filed within 72 hours after death with the Maryland notified at 10c. City, Town or Location Director 10d. Inside City Limits · 28a-f 1 X Yes 2 ☐ No Maryland Prince George's Fort Washington ō Street and Number 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 12207 Mira Bay Circle 20744 <u>United States</u> 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: Black 3 Widowed 4 X Divorced Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important If item 27 is marked other than "naturany or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Physician 5+ Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Hazel Graham <u>Leon Turner</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 19a. Informant's Name/Relationship (Type, Print) Paul-Harvey Weiner/Grandson 8307 Flower Avenue, Takoma Park, Maryland 20744 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Nov.30°, 201 cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Harmony 11/23/2012 Landover Maryland 7400 Georgia Avenue, North West 21. Signature of Funeral Service Lice alleric Washington District of Columbia 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Acute Respiratory Failure disease or condition Medical resulting in death) **Examiner** Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Dav Year ed by the a Unknown 9 Unknown ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Congestive Heart Failure: Dementia Completed 1 Yes 2 No 3 Probably 4 No Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? After this certificate 1 ☐ Yes 2 ☐ No ☐ Yes 2 🕱 No 25. Was case referred to medica filled in by the funeral director, æ 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No death. within 24 hours after death.

To the Funeral Director: A completed filled in by the factor. Accident Investigation Suicide 6 \square Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical **Examiner:** On the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and time of certifier 29d, Date signed (Month, Dav. Year) November 28, 2012 vho completed cause of death (Item 23a) (Type, Print) 12017 Fort Washington Road, Fort Washington, Maryland 20744 Edger Potter,M.D. 31. Date filed (Month, Day, Year) 32. Registrar's S State 2 9 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month November 28, 2012 Josephine Castelli Tana 7:25 aM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Renaissance Gardens at Riderwood Village Silver Spring P . G. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Hours 084-18-7933 (Month, Day, Year) Director 1 M 2 XF Feb. 12, 1923 NY permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any inluy or other traumaft event, the Medical Examiner must be notified at any inluy or other traumaft event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo MD P.G. Silver Spring 1 Yes 2 1 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20904 3160 Gracefield Road, #3120 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. Specify: White ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Secretary Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Antonio Castelli Rose Annalone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11001 Fruitwood Drive, Bowie, MD 20720 Rosemarie Tana/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Dec. 3, Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD 21. Signature of Funeral Service Licensee

22. Name and Address of Facility
Francis J. Collins Funeral H
500 University Blvd. W,. Sil

23a. Part 1. Effer the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ Arteriosclerotic Cerebrovascular Disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Hypertension 20 yrs Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): and and law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year ed by the a 9 Unknown g Unknown 0.0 signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Congestive Heart Failure, Dementia (End-Stage) Completed 1 Yes 2 No 3 Probably 4 Unknown is certificate has been si director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No or Attending Physician: The 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending work?
1 Yes 2 No injury Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)

Records, **Division of Vital** To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this or propeletely filled in by the funeral director after this completely filled in by the funeral director.

> State Registrar

Medical

29a. Certifier (Check

29b. Signature and title of certifier

30. Name and address of person who completed Eileen Gemmell, CRNP

31. Date filed (Month, Day, Year) NOV 2 9 2012

completed cause of death (Item 23a) (Type, Print) CRNP 3160 Gracefield Road, Silver Spring, MD 20904 82. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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		1	For State Registrar			ificate of L			Reg. No	2012	40902
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		7	2-1-1	/	2. Date of De	ath Day	Year	3. Time of Death
	Medic	al .	12 VIV 4a. Facility Name (if not institution, give street and	number) (1/4	EMEY	r Location of Death	NUVEML	ER 21	, 2012	18:55 M
-	Examin	· .	THE JONUS HOPKIN 5. Social Security Number 6. Sex	IS HOSPI	TAL	BAHIN If Under 1 Year	MORE C	+4		County of Death	
	Funeral Director		389–46–4898 Usual Residence of Decedent	7. Age (In yrs. Ia F 57		Months Days	Hours Min.	8. Date of Bir (Month, Da June 1	y, Year)	Coun	place (State or Foreign try) Onsin
	Marylend 28e-f shov	Funeral Director	10a. State 10b. County MD Anne Arundel		, Town or Loca rnold	ation				1	0d. Inside City Limits 1 ☐ Yes 2X No
	vith the	eral D	10e. Street and Number 1262 Doubleday Drive			10f. Zip Code 21012			10g. Citiz	en of What Cour	try?
960	72 hours after death with the Manylend n'meturel", or Iteme 23e or 28e-f show edical Exuminer must be notified at	۾	11. Marital Status 1 Never Married 2 M Married 1 Never Married 2 M Married 1 M S	Decedent Ever in U.S d Forces? Yes 2 No Give ir Dates.	lf '	as Decedent of H Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)		4. Race - Americ Black, White, of pecify: W	
21215-0036	within 72 hours agiene. Pr. then "neturel the Medical Ex	Completed	15. Decedent's Education (Specify only highest grade completed the completed specified by the completed specified by the completed specified by the completed specified by the complete specified by the	e (1-4 or 5+)	(Give kii life. DO	nt's Usual Occup nd of work done of NOT use retired) Enginee	during most of worki	ng	Priv	d of Business/Ind /ate ineering	
Maryland	should be filed within 7/ and Mental Hygiene. is merked other then eumatic event, the Ma	To Be	17. Father's Name (First, Middle, Last) Harold Trehey 18. Mother's Name (First, Middle, Maiden Veronica Kane								
	nd 2 shoul ealth and f m 27 is me ner treums		19a. Informant's Name/Relationship (Type, Print) Elizabeth Trehey / Wif		19b. Mailing Address (Street and Number or Rural Route Number, City or 1262 Doubleday Drive Arnold, MD						code)
Baltimore,	perrat. Page 1 end 2 should be filed within 7 Decartment of Health and Mental Hygiene. Insportent: If Item 27 is merked other then ery Injury or other treumatic event, the M. 9. 12.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal 1 4 ☐ Donation 5 ☐ Other (Specify)	rom-State Ce	t Point	tory or other place. Cemete:	ry Decen	nber 04)12	'Wes	ation - City or To	, NY
Ba	Derari Derari On Prari		21 Signature of Juneral Servivi Licensee	Vene	20 Z	Name and Addre Barranco 195 Ritc	ss of Facility & Sons, I hie Hwv.	A. Se	verna verna	Park Fu Park, M	neral Home D 21146
4	Priysician/ Medical Examiner		Mi	nat caused the death n each ne. to (or as a consequitochondri	ence of):	grail		r respiratory ar	rest,		Approximate Interval Between Onset and Death
90	te be executed sysicien and he buriai-transit	dical Examiner									
. Box 68760	Hospitel or Attending Physicien: The law requires that the deeth certificate be executed 24 hours after death. Funerel Director: After this certificate has been signed by the attending physicien and stely filled in by the funeral director, page 2 should be detached for use as the burial-transit		in the past 12 months?	outcome of pregnar Live Birth 2 ☐ Fetal Pregnant at time of d Jnknown	Ideath 3 🗌	3d. Date of delive	ery Day Year				
ls, P.O	uires that the signed by	ed by Pr	Part II. Other significant conditions contributing	to death but not resu	ulting in the un	derlying cause gi	ven in Part I.	23e. Did t	1		e cause of death?
Division of Vital Records,	The law require: ate has been signed 2 should I	omplet						24a. Was auto perfo		24b. Were autop prior to condeath?	osy findings available mpletion of cause of
tall	cien: Gertifica	Be	25. Was case referred to medical examiner?				lace of Death (Check				
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o uc	ath. r: Afte	icate	1 Natural 5 ☐ Pending (I	Month, Day, Year)	injury	worl	k? Yes 2 □ No	ed. Describe	low injury i	occurred	
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	To the Hospi within 24 hou To the Funer completely fil	Medical	29a. Certifier (Check Check only one) Certifying Physician: To the Check only one) Certifying Nurse Practition	basis of examination	and/or investig	gation, in my opini	on, death occurred at	the time, date a	and place, a	and due to the cau	use(s) and manner stated.
	5 × 5 0		29b. Signature and title of certifier		u s	29c. Licens	e number		29d. Date	signed (Month, I	Day, Year)
	8,2x		30. Name and eddress of person who completed	cause of death (Item	23a) (Type, Pri	nt)	117617		NOVE	MUCK_	X1, XU13
	43.		30. Name applied dress of preson to completed benjumin J. Barnes. 31. Date filed (Month, Day, Year)	N.D.	180	DO ORIZI	ALLS STR	EET, E	3A/ti	MORE, 1	ND 21287
	Sta Registr	6	31. Date filed (Month, Day, Year) NOV 3 0 2012	2. Resistrar's Signati	ure A	arkel				/	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death Wendell Lee Vanscoy Physician/ November 2012 20, 5:10 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death
Carroll County Golden Living Center Westminster Social Security Number 219–32–8269 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year)
March 7, Davs Hours **Director** 1 **X** M 2 □ F 77 1935 W. Virginia Usual Residence of Decedent 28a-f show at 10c. City, Town or Location 10d. Inside City Limits Director notified Maryland Carroll County Westminster 1 Yes 2X No č Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 1512 Honesty Drive Funeral 23a 21157 United States or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. than "natural", or iter he Medical Examiner 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married within 72 hours after 3altimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Specify: white 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) salesman traumatic event, the sales other Department of Heath and Mental Hy. Important: filten 27 is marked other any injury or other traumations. filed val Hya Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ John Vanscoy Vivian Abels 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wendy L. Johansson/daughter 1512 Honesty Drive Westminster, Maryland 21157 20a. Method of Disposition 20b. Place of Disposition (Name of Nov. 21, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Carroll Cremation 4 ☐ Donation 5 ☐ Other (Specify) Hampstead, Maryland 2012 21. Signature of Funeral Service Lio h 22. Name and Address of Facility Eline Funeral Home M01072 Main Street, Hampstead, urra 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Athenoscleron Medical Due to (or as a consequency of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 the as attending p IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No g Unknown g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed? Yes 2 No death? ate 1 Yes 2 No Hospital or Attending Physician: certific director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 2 🗆 No Investigation Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death only one) occurred at the time, date and place, and due to t he cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) aca

State

JACQUELINE 31. Date filed (Month, Day, Year)

Registrar

Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALQUELINE WEARN 488 A PODLE ROAD

32. Registrar's Signature

2012

MD 21157

ESTMINSTER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for State Registrar	State o	f Marylan				ealth a Death	ınd Me	ental Hy	giene Reg. No.	2012	ruaur	
	· ·		1. Decedent's Name (First, Middle, Last)					2. Date of Death Month Day Year 3. Time ol Death							
	Physici /Medic		Virginia Rich		odman						Vovembe		3, 2012	5:55 P M	
	Examin	er	4a. Facility Name (If not institution, give s Buckingham's Choi		mber)			. Town, or .dams1	Location of	f Death		4c.	4c. County of Death Frederick		
	Funeral		5. Social Security Number 6. Sex		7. Age (In yrs.	last birthday)	If Unde	r 1 Year	If Under 2		8. Date of Bir	rth	9. Bir	tholace (State or Foreign	
	Director		111-01-7761	M 20 F	97	Yrs.	Months	Days	Hours	Min.	Month, Da	1, 19		w Jersey	
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits	
	Maryli 1 sho	ō	MD Frederick			Adamst								1 ☐ Yes 🌠 No	
	r 28a	Director	10e. Street and Number					p Code			1	10g. Citi	izen of What Co	ountry?	
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and		To Be	William Howe Rich	ı							awson	,	,		
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	and 2 ealth a n 27 i		Christopher Woodma	n (S	Son)								lorado		
altimore,	Pages 1 nent of Ho int: If iter iry or oth		20a. Method of Disposition 1 ☐ Burial 2 ※ Cremation 3 ☐ R	emoval from	State	Place of Dispo cemetery, crer			1		ate		ocation - City or		
<u>=</u>	it. Pa irtmen irtent: njury		4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service License		Smi								hsburg,	MD	
Ba	permit. Pages 1 and 2 should be Depertiment of Health and Menta Important: If item 27 is marked any Injury or other traumatic evone.	6 1	Dan Leici	J.	MO161	2 K	eene 06 E	y & E	Basfor	ŕd P.	A. Fur	neral	Home MD 217	701	
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paris	Physician		Immediate Cause (Final disease or condition	51	-YOK	-								Onset and Death	
5.	/Medical Examiner		resulting in death)	Due to	(or as a conseq	juence of):	11								
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.O. Box	death e atter d for u	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	4☐ Pregr	oirth 2 ☐ Feta nant at time of d		Ectopic p Other (s	pecify)					Month	Day Year	
0	res that the de signed by the a be detached f	hys	9 🗆 Unknown	9□ Unkn											
	ries th signed	b	Part II. Other significant conditions con	itributing to d	eath but not res	sulting in the u	nderlying	cause give	en in Part I.		1	Yes 2		o the cause of death? robably 4 □Unknown	
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<u>≥</u>	al or A s after il Direct	Certification:	4 Homicide determined	build	e of Injury - At h ing, etc. (Speci	fy)		.,,			City or To	own, State	a)		
	To the Hospital or within 24 hours after To the Funeral Dit completely filled in	edical (29a. Certifier 1 Certifying Phy (Check only one)	ner: On the b	e best of my kno basis of examina iner stated.	owledge, deat ation and/or in	h occurre vestigatio	d at the tim n, in my of	ne, date an pinion, dea	d place, a	and due to the ed at the time	cause(s , date and) and manner a d place, and du	s stated. e to the cause(s)	
	To the within 2 To the comple	Me	29b. Signature and title of certifier				25	oc. License	e number			29d. Da	te signed (Mon	th, Dey, Year)	
			1 les	Mr) (]	260	417	>		11.	-28-2	2012	
	5		30. Name and address of person who co	mpleted cau	se ol death (Iter	m 23a) (Type,	Print)			FINE	10.000		(1) ~	11. Dey, Year) 2012	
	Sta	te	31. Date liled (Month, Day, Year)	05 C 32. F	Rigistrar's Signa	ature 10	uns	CV .	W	1 1 6	DEVIL	16-1	-113 2	-1/6/_	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Windsor 23, 2012 Holmes Isabelle November 11:50 amM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Westminster Carrol1 Golden Living 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours Min. 228-12-4598 93 Director 1 □ M 2 🕱 F Aug 15, 1919 Virginia and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show wither traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Mt. Airy 1x Yes 2 ☐ No Carroll Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21771 611 Calliope Circle 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 2 Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Flementary/Secondary (0-12) College (1-4 or 5+) Own home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Theresa Alice Williams George Pemberton Holmes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Ronald Windsor - son 1050 Huntfield Road, Westminster, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Pine Grove Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 EBurial 2 ☐ Cremation 3 ☐ Removal from State 11-28-2012 Mt. Airy, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sergice Licenses 22. Name and Address of Facility 8 E. Ridgeville Boulevard, Mt. Airy, Maryland Stauffer Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner ebrovas Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine r as a consequence of, To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for the production. 2-3 that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) g Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 N Yes 2 1 25. Was case referred to medical Be 26. Place of Death (C > k only one) ြင် Other: 1 Yes 2 🗋 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: **Natural** 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 26 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) dure, west whaten

DHMH 17 Rev 06-2011

Registrar

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egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#10a-c.e.f.perFH, G937, 3/29/2013, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No.2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 19,2012 12:00 PM James Henry Whitenack 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince Georges 15014 Nashua Lane 9. Birthplace (State or Foreign Country) NY 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In yrs. last birthday) Days Hours Min Months 11/30/1931 071-24-5835 80 1 X M 2 □ F Usual Residence of Deced 10c. City, Town or Location
Bowie 10d. Inside City Limits Prince George's VA MD 1 Yes 2 X No Fairfax Springfield 10g. Citizen of What Country? ^{10f.} **20716** 15014 Nashua Lane 8449 Thames street USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married 2 No 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working Elementary/Secondary (0-12) life. DO NOT use retired) College (1-4 or 5+) Loan Officer Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Elmer Whitenack Flora Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15014 Nashua Lane, Bowie, MD 20716 Joanne Morley/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 😾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21, Metropolitan Crematory Alexandria, VA Signature of Funeral Service Licensee 22. Name and Address of Facility Jefferson Funeral Chapel MOISAG 5755 Castlewellan Dr.,Alexandria,VA 22315 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Cardiovascular disease or condition resulting in death) Due to (or as a consequence of):

Physician/ Medical Examiner

attending physician and for use as the burial-transit

signed by the a

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page 2

funeral director,

completely filled in by the

29b. Signature and t

31. Date filed (M

son who completed

To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics

certificate be

Division of Vital Records, P.O. Box 68760

Physician/

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Department of Health and Important: If item 27 is n any injury or other traumonce.

Examiner

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within 72 hours after death

should be filed within 72. n and Mental Hygiene.

altimore, Maryland 21215-0036

Physician/Medical Examiner <u>م</u> Certificate: To Be Completed

by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.	
nysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	23d. Date of delivery Month Day Year
Completed by Pl	Part II. Other significant conditions o	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No
Be (25. Was case referred to medical examiner?	only one)	
To [1 Yes 2 No	Hospital: 1 \square Inpatient 2 \square ER/Outpatient 3 \square DOA Other: 4 \square Nursing Hor	me 5 Mesidence 6 🗆 Other (Specify)
Certificate	27. Numer of Death Natural 5 Pending 2 coldent Investigation	(Month, Day, Year) injury work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Medical	(Check Medical Exam	sician: To the best of my knowledge, death occurred at the time, date and place, an ner: On the basis of examination and/or investigation, in my opinion, death occurred at se Practitioner: To the best of my knowledge, death occurred at the time, date and place.	the time, date and place, and due to the cause(s) and manner state

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number

0101048216

9409B Old Burke Lake Rd. Burke, Virginia 22015

29d. Date signed (Month, Day

2017

Registrar

State

Bin

DHMH 17 Rev 06-2011

(Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

1500 Forest Glen Road, Silver Spring, MD 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Yodit Negussie, MD
31. Date filed (Month, Day, Year)

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VIIDEI DWIGHT V	VIIS	1- For State	Stat	te of Maryland			ent of Health a ete of Death	nd Mentai r		See Ma	201	2 4090
Physici		Registrar 1. Decedent's Nam							2. Date of Dea		Year	3. Time of Death
Medical Exam	liter	WILBUR 4a. Facility Name (DWIGHT if not institution,	WILSON J	R.	_	4b. City, Town,	or Location of Dea	Novembe		Ounty of Death	2118 hrs
)		11533 High	land Farm C	-			La Plata	0. 2004.011 0. 204		Charles		
Funeral Director		5. Social Security N			ge (In yrs. la	ast birth		ear If Under 24Hi	<u></u>		Foreig	
Director.		Usual Residence of		X M 2 F	35		Yrs.		APRIL	20,1	977 Co.	untry) DC
w any		10a. State 10b. County 10c City, Town or Location										10d. Inside City Limits
Maryland 28a-f show d at once.	Director	MD 10e. Street and Nu	CHARLES	;	LAPL	ATA	10f. Zip Code			10g Citizer	n of What Cour	1 Yes 2 No
15-0036 filed within 72 hours after death with the Maryland Hygene. ed other thao "oatural", or items 23a or 28a-f sho t, the Medical Examioer must be notified at once.	US 11533 HIGHLAND FARM COURT 20646 US							-		,		
ith with tems 23 st be ng	Funeral	11. Marital Status 1 Never Marrie	ed 2 X Marr	12. Was Deceden		S.	13. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (§ an, Mexican, Puert	Specify Yes or No to Rican, etc.)	0- 14	4. Race - Americ	can Indian, Black,
fter dez I", or i		3 Widowed	_	1 X Yes 2 ced If Yes, Give Year	2 No		_ ¥	No specify:		Sa	pecify: BLA	CK
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5-0036 led within 72 hours afte Hygiene. other thao "oatural", the Medical Examioer	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 2 ENTREPRENEUR PRIVAT							IVATE			
5-00 iled wit Hygien I other									urname)			
imore, MD 21215-0036 Pages I and 2 should be filed within 7 ment of Health and Mental Hygiene. Inot: If item 27 is marked other thao or other traumatic event, the Medica	WILBUR D. WILSON SR. SHARON JONES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town,								or Town State	Zin Code)		
e, MD and 2 short treat and tree tree tree tree tree tree tree tre	CRYSTAL WILSON/WIFE 11533 HIGHLAND FARM COURT, LAPLA											
ore, M es 1 and 2 of Health of Health If item 2		20a. Method of Dispose 1 X Burial 2		3 Removal from S	tate TIAD	Place of	Disposition (Name of c	cemetery,	Date		cation - City or	
### # # # #									5-2012	LAN	DOVER,	MD
Department of the partment of		Charles	· E. ~	Gun ?	100g	81	22. Name and Addre					
Physician /Medical		23a. Part I. Enter th failure. List on	ly one cause on	mplications that cause each line.)	Do not						Approximate Interval Between Onset and
xaminer		Immediate Cause (or condition resulting		Due to (or as a cons		f):					,	Death
Same of the	_	Sequentially list conif any, leading to im		b		٤١.						
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Box 68760, c death certificate be execute the attending physician and ed for use as the burial - tran	Physician/Medi	IF FEMALE: 23b. Was decedent		23c. If yes, outco			Fetal death 3	Ectopic pregn	nancy		Date of delivery	ay Year
OX 6. sath cert attendii	sicia	past 12 months	s? No 9 ☐ Unkno	4 Pregnant a	t time of dea		Other (Specify)					ay rour
the d		Part II. Other signif		9 Unknown	th but not re	sulting	in the underlying cause	given in Part I.	23e. Did t	tobacco use	e contribute to t	he cause of death?
ords, P.O. w requires that th as been signed by should be detach	ed by								1 Ye	s 2 N	No 3 Prob	ably 4 🗹 Unknown
cords law requ has beer	Completed								24a. Was auto	psy	prior to a	opsy findings available ompletion of cause of
tal Rec		05.14							1 ✔ Yes	ormed? 2 No	death? 1 ✓ Ye	s 2 No
Division of Vital Records, tal or Atteodiog Physician: The law requiring after death. *I Director: After this certificate has been sited in by the funeral director, page 2 should be the funeral director, page 2 should be the funeral director, page 2 should be the funeral director, page 2 should be the funeral director, page 2 should be the funeral director.	o Be	25. Was case referr examiner? 1 ✓ Yes	red to medical	Hospital: 1 Inpatie	ent 2	ER/Out	patient 3 DOA	Other Nursi		Residence	e 6 🗸 Other:	Scene
liog Ph After t funeral	-	27. Manner of Death	h	28a. Date of Inju (Month, Day,)	ury Year)	28b. Ti		jury at Work?	28d. Describe			
Atteoder death	Certification:	2 Accident	5 Pending Investig	ation 289 Place of Ir			20.00 pm —	Yes 2 X No	unkno		Number of Bus	al Route Number, City
3 Suicide 6 X Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and or Town, State) 11 Ct. La Plate								State)	533 Hig	hland Farm		
Division To the Hospital or Atteod within 24 hours after death To the Fuoeral Director:	<u>8</u>			siclan: To the best of m					d due to the cau	se(s) and n	manner as state	
Tot withi Tot	Medi	29b. Signeture and		and manner stated.	IIIII allori ai	Id/OI IIIV		nse number	at the time, date		te signed (Mon	
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	ate	I heodore M 31 Date filed (Ment	i. King, Jr., M h. Qay,Year)				er 900 W. Balti	imore Street, E	saltimore, M	21223 ט		
Regist		DEC 1 U	2012	32. Registra	MAGA	Kal						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death IL Day Physician/ /Ω Wi 11:25PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Luch Kaven merse 20 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birtholace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours (Month, Day, Year) 217-50-3799 Director 1 X M 2 □ F 67 /1945 Pennsylvania 10 rge 1 end 2 should be filed within 72 hours after death with the Maryland nt of Heelth end Mentel Hyglene. It if the 22 yr is marked other than "natural", or items 23a or 28a-f show or other trainantic event, it is Maclo 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No Baltimore MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 3123 Guilford Avenue 21218 12. Was Decedent Ever in U.S. Armed Forces?

1 M Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3X Widowed 4 ☐ Divorced Specify: White Year or Dates. Vietnam 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Carpenter Construction 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Andrew Wiley Odgers 19a. Informant's Name/Relationship (Type, Print) (Brother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21161 James B. Rutledge III 4660 Norrisville Rd. White Hall, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Dec Date 7, 20c. Location - City or Town, State permit. Pege 1 e Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 201 <u>Madonna, Maryland</u> Bethel Cemetery E.G. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kurtz & Son Funeral Jarrettsville. .A. Home. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician/ ances disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The lew requires that the death certificate be executed within 24 hours after deeth.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should he detached for the funeral director. Exami Lause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To I 1 ☐ Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 M Natural 5 Pending work?
1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

5

State Registrar

Medical

29a. Certifier

only one)

31. Date filed (Month

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3900

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year,

29c. License number

34359

OHIO

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. Amend 28d-f, per me, g940 6-25-13 sm State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. N2 0 | 2 Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Whitting ton **Physician** rellaune 1427 M 2012 Tarrison 20 /Medical 4b. City, Town, og.Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Keninsula Regional Medical Salisbury Micomico Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Yrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 218-24-736 9 Usual Residence of Decedent 102M 2□F Mary Director land 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits , or items 23a or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Somerset Director Marion Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1. S. A 21838 Hudson's 1876 Rol Corner Funeral filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 © Yes 2 □ No If Yes, Give Year or Dates: 1952 -54 Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced "naturai", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Somerset County Elementary/Secondary (0-12) College (1-4or 5+) Superintendent Schools 12th grade

17. Father's Name (First, Middle, Last) Public queurs Pages 1 and 2 should be filed in ment of Health and Mental Hygic ant: If item 27 is marked other 18. Mother's Name (First, Middle, Maiden Sumame) Be Cottman Whittington Alphonso 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Morion Station Mozins 28767 Hueson's -ouise E. Whittington - wife Rd. Corner 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o important: if eny injury or once. Gardens 12-1-12 Hebran Springhill Mem. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Anthony E. Ward Jr. F. H. 30639 Hampden Princess Anne, MD, 21853 Ave, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): **Physician** /Medical Examiner 31 IP craniotom Men Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 180ma Due to (or as a consequence of): Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER The law requires that the death certificate be executed SUN Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 3 23b. Was decedent pregnant in the past 12 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) signed by the at id be detached for 9 Unknown 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22 No certificate 2□ No 1 ☐ Yes 1 Tes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) this After thi funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 2 ☐ Accident 5 Pending investigation To the Hospitei or Attendir within 24 hours after death.
To the Funerei Director: Al completely filled in by the fu М 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0058812 26/12 who completed cause of death (Item 23a) (Type, Print) 82 ilchnan Rd Salisban Kruber 220 MMNDIR 31. Date filed (Month, Day, Year) NOV 28 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / D	epartment of Health	and Mental	Hygiene					
		State Registrar		Certificate of Death)	Reg. No. 2	112	40911			
Physici Medi		1. Decedent's Name (First, Middle, Last) James H. Wilkinsky				of Death 11/27 ^D 201	2 Year	3. Time of Death 1145pm м			
Exami		4a. Facility Name (if not institution, give stre	et and number)	4b. City, Town, or Location		4c. County of Death					
		BWMC 5. Social Security Number 6. Sex	7 And the same took high	Glen Bu				Arundel			
Funeral Director		183-16-6508	7. Age (In yrs. last birth)	Months Days Hours		of Birth h, Day, Year)	9. Birthp Count	place (State or Foreign try)			
>		Usual Residence of Decedent	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	rs.	3/5/	1923		PA			
yland yland f sho	Stor	10a. State 10b. County	10c. City, Town				11	0d. Inside City Limits			
e Mar r 28a	Director	MD Anne Arus 10e. Street and Number	ndel	Severna Park				1 Yes 2xxNo			
ith th	ral	180 Ritchie Hwy.	A 222	10f. Zip Code		10g. Citizen o		·			
ems	Funeral		Apt. 322 Was Decedent Ever in U.S.	13. Was Decedent of Hispanic C		r No- 14 Ba	USA ace - America				
fter de	by	1 ☐ Never Married 2 ☐ Married	Armed Forces? XXX Yes 2 □ No WWII	13. Was Decedent of Hispanic C If Yes, specify Cuban, Mexic		J.	ack, White, e	etc.			
OOS ours a tural"	Completed	3 Widowed 4 🖽 Sivorced	If Yes, Give Year or Dates.	1 ☐ Yes 🛣 No Specit	ry:	Speci	fy: WI	nite			
15 ho	m de	15. Decedent's Educa (Specify only highest grade of	completed)	ecedent's Usual Occupation Give kind of work done during mo fe. DO NOT use retired)	ost of working	16b. Kind of	Business/Ind	lustry			
d 212 led within Hygiene. other tha ent, the I		Elementary/Secondary (0-12)	College (1-4 or 5+)	ht Auditor		Hot	:e1				
land 21215-0036 be filed within 72 hours after death with the Maryland ental Hygiene. *ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	o Be	17. Father's Name (First, Middle, Last)		18. Mot	ther's Name (First, Mi	ddle, Maiden Surnar	ne)				
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam	일				a Wilkins						
ore, Maryland 21. 1 and 2 should be filed with of Heath and Mental Hygien if item 27 is marked other trother traumatic event, the	1	19a. Informant's Name/Relationship (Type,	,	Mailing Address (Street and Numi				lode)			
re, M 1 and 2 s f Health item 27 other tra		Mary Ann Neiman 20a. Method of Disposition	20b. Place of I	05 Crosslanes W	Date Date	on, MD 21 20c. Location		wn. State			
Page 1 ment of ant: If it		1 XXBurial 2 ☐ Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)	novar nom otate	crematory or other place) d Veterans Cem							
Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or other once.		21. Signature of Funeral Service License	rialylan	22. Name and Address of Faci	iityHardestv	Funeral	Home.	P. A.			
n 82569	0. 7	PORMY UIL		12 Ridgely Ave	. Annapo	lis, MD 2	1401				
		23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one c	tions that caused the death. Do not ause on each line:	/ /	s cardiac or respirato	ory arrest,		Approximate In rval Between			
Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	TCUTE M	10 cargias	Inture]	la		Of set and to ath			
Examiner		researing in dealing	Que to (or as a consequence of	Arlen 1	11ema			Daligoni			
	iner	Sequentially list conditions, if any, leading to immediate	Due to (or as a conservence of)	111119	1000		- 2	20 4 641 1			
cuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.									
rate be executed physician and the burial-transit	a	resulting in death) Last	Due to (or as a consequence of)								
box os / bo death certificate be executed e attending physician and ed for use as the burial-transi	edical	3 d .									
certific nding use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c.	If yes, outcome of pregnancy			23d E	ate of delive	erv.			
Geath of death of atter	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 Ectopic pregnancy 5 Other (specify)				Day Year			
at the d	Phy	9 Unknown Part II. Other significant conditions contril									
ords, F.O. Box 68 // requires that the death certificate been signed by the attending postbould be detached for use as thould be detached for use as the state of	þ	Part II. Other significant conditions contin	buting to death but not resulting in	nie underlying cause given in Par	200.	Did tobacco use cor		e cause of death?			
Hecords, The law requires ate has been sig	Completed				_			psy findings available			
e has	g l					autopsy performed?	prior to con death?	npletion of cause of			
an: The tifficate tor, pa	ا به ا	25. Was case referred to medical		26. Place of De	ath (Check only one)	Yes 2 No	1 Yes	2 1 1			
VITAI nysician: nis certific I director,	To B	examiner? 1 \(\text{Yes} \) 2 \(\text{Vo} \)	oital: 1 Inpatient 2 ER/Outp	_ Other: _	Nursing Home 5	Residence 6 🗆 Ot	her (Specify)				
ing Ph		27. Manner of Death 1 Natural 5 Pending	28a. Date of injury (Month, Day, Year) 28b. Tin	ry work?		ribe how injury occur	rred				
VISION or Attendir ifter death. Sirector: Af	ertificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, farm	M 1 Yes 2							
I or A after after Direct din by	O	4 Homicide determined	building, etc. (Specify)	, street, factory, office		ion (Street and Num r Town, State)	ber or Rural F	Route Number,			
DIVISION OF VICAL RECORDS, F.O. In the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.	Medical	29a. Certifier 1 Certifying Physicia	n: To the best of my knowledge, de	ath occurred at the time, date an	d place, and due to t	he cause(s) and mar	ner as state	d.			
the H hin 24 the Fu	Med	only one) 3 Certifying Nurse Pr	On the basis of examination and/or in actitioner: To the best of my knowle	dge, death occurred at the time, d	occurred at the time, of late and place, and du	late and place, and d e to the cause(s) and	ue to the caus manner as st	se(s) and manner stated. tated.			
To wit		29b. Signature and fittle of certifier	LI.S.	29c. License number	00611	29d. Date sign	ed (Month, D	av, Year)			
1.5		30 Name and address of press who	loted course of death (have one) or	D V U	179	//_	1 x 8/	16			
#103r		30. Name and address of person who comp	MD /Y//	Madian	Mar / Viv	+ HON	Aveni	· Md 2106"			
Sta	te	31. Date filed (Month, Day, Year) NOV 3 0 201	32. Rugistrar's Signature	sace.		(7-1111				
Registr	ar	MUY 3 0 2012	- severa B.	gave							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) NOV. 2012 Physician/ 12:30 A.M LOOMIS OGDEN WISE TTT Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** WORCESTER ATLANTIC GENERAL HOSPITAL BERLIN Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Days Hours 221-24-7103
Usual Residence of Decedent 71 1**X** M 2 □ F Director MAY 2, 1941 DELAWARE 10d. Inside City Limits 28a-f shov 10c. City, Town or Location 10a. State 10b. County notified at Director Yes 2 No \$ELBYVILLE SUSSEX DELAWARE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number must be 19975 23a 403 BRANCH CT. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Examiner Black, White, etc. Armed Forces: Ь þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE "natural", Completed 3 Widowed 4 Divorced Year or Dates. 1962-66 th and Mental Hygiene. 27 is marked other than "natul traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) ASPHALT PAVING VICE PRESIDENT 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ STEELE **GWENDOLYN** LOOMIS OGDEN WISE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 403 BRANCH CT., SELBYVILLE, DE 19975 Department of Health ar Important: If item 27 is any injury or other trau RENDA J. WISE/WIFE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State DAGSBORO, DELAWARE REDMEN'S MEMORIAL CEM. 12/4/12 4 Denation 5 Other (Specify) 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE 19975 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Providen/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner tic Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying falls to to as a consequence of: Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy perform 1 Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medica a Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No ၉

Division of Vital Records,

11-28-2012

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Ogden

GTC IVP

To the Hospital within 24 hours a To the Funeral Completely filled

Certificate:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) NOV 29 State 2012

29b. Signature and title of certifier

27, Manner of Death

1 Natural 2 Accider

2 Accident
3 Suicide

4 Homicide

29a. Certifier (Check

5 Pending

Investigation

determined

6 Could not be

32

28a. Date of injury (Month, Day, Year)

Healthway Drive, Berlin, MD 21811

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

injury

28c. Injury at

work? 1 ☐ Yes 2 ☐ No

74353

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 👚 Certifying Nurse Practition of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

28

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nov. 19, 2012 Armando Yela Victor 3:00рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death Montgomery Manor Care Silver Spring Silver Spring Social Security Number **Funeral** . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 | F 216-08-7924 33 671471979 Wash. DC **Director** Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Montgomery Silver Spring 1 🗆 Yes 2 ื No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 9616 Dilston Road 20903 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☑ Yes 2 □ No SpeChylatemalan Specify: White "natural" Completed 3 Widowed 4 Divorced Year or Dates of Health and Mental Hygiene.
item 27 is marked other than "natur other traumatic event, the Medical other traumatic event, the Medical other traumatic event, the Medical other traumatic event. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Carpenter Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Victor Yela Aura M.Lopez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aura M.Lopez/Mother 9616 Dilston Road Silver Spring, Md. 20903 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of I
Important: If it
any injury or or 1 X Burial 2 Cremation 3 Removal from State Gate of Heaven 11/27/2012 Silver Spring, Md 4 Donation 5 Other (Specify) Signature PATETPAD RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Uncal herniation Medical resulting in death) Due to (or as a consequence of Examiner Cerebral edema Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events southing in death). Let Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial (Oligodendroglioma Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Day Yea Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 Yes 2 No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital ᅆ 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: Natural
Acciden 28d. Describe how injury occurred 5 Pending injury work?
1 Yes 2 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined 29a. Certifier 😾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature nd title of certifie 29c. License number Nov.26,2012 D47867

State Registrar 4701 Randolph Road #101 Rockville, Md 20852

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Zuniga MD

Oney
31. Date filed (Me

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene StateRegistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1497 29 / 29 1 2 2:58 PM Sue Zdenek Marv Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Center Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 01911-09 Year)941 Maryland 213-40-2359 Director 71 1 □ M 2 🖾 F Usual Residence of Decedent 27 is marked other then "neture!", or items 23s or 28e-f show treumetic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Harford Havre de Grace 1 X Yes 2 □ No the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21078 U.S.A. 201 B Pointe Way 11 Marital Status 12. Was Decedent Ever in U.S.
Armed Forces?

1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Ş Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes Give 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hyglene. Elementary/Secondary (0-12) College (1-4 or 5+) Pharmacist Health Care Be Pege 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Regina Harkins Gerald Larner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 B Pointe Way Havre de Grace, MD 21078 John G. Zdenek (husband) 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Pege 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State West CHester. RA Ferris & CO 1 Burial 2 X Cremation 3 Removal from State 12/04/2012 4 ☐ Donation 5 ☐ Other (Specify) Pennsylvania 21. Signature of Funeral Service XIO 22. Name and Address of Facility Zellman Funeral Home, P.A. 123 S.Washington St., Havre de Grace, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician colorectal ears Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unicase or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): signed by the ettending physicien and defected for use as the burlal-transit Due to (or as a consequence of): Physician/Medical The lew requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Dav 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 호 Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown To the Hospitel or Attending Physician: The lew require within 24 hours efter death.

To the Funerel Director: After this certificete hes been si completely filled in by the funerel director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical BB 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) VVOS PLA 2 X/No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending injury Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) November 30 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles ST DEWSON MO Mynes 31. Date filed (Month egiştrar's Signatur State Registrar

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Weeken	-			_	Distr.	-	

	1- For State Registrar		te of Death	Reg. No.				
Physician/ Medical Examine	1. Decedent's Name (First, Middle, La 2006/14 Shipit	y Auerbach		2. Date of Death Month Day Year December 12, 2012	Day Year 2315 hrs 2315 hrs			
	4a. Facility Name (if not institution, gir Prince George's Hospital	ve street and number)	4b. City, Town, or Location of Death Cheverly		4c. County of Death Prince George's			
Funeral Director	5. Social Security Number 5. Social Security Number 6. S 124 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ex 7. Age (In yrs. last birth	day) If Under 1 Year If Under 24Hr. Months Days Hours Mir	_ 1 11 1 0 1	9. Birthplace (State or Foreign Country)			
Maryland 28s-f show any d at once. rector	10a. State 10b. County	1607GES 10c. City, Town o	nbeit		10d. Inside City Limits 1 Yes 2 No			
h the Maryland 33a or 28a-f sh ootified at once	10e. Street and Number	Road	10f. Zip Code 20770	10g. Citizen of Wha	S.A.			
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f sho r traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	3 Vildowed 4 Divorce	Armed Forces? 1 Yes 2 No d If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto Yes 2 No specify:	Specify:	unite			
1215-0036 Id be filed within 72 hours at fental Hygiene. narked other than "natural event, the Medical Examin on Be Completed by	15. Decedent's Education (Specify of Elementary/Secondary (0-12)		ty of DC					
D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medical To Be Compiled.	I LEOPOIA HU	erbach	Éler		Y			
e, MD 21 t and 2 should Health and Me item 27 is ma r traumatic ev	Jennine Muerol	ich / oaugner I	Mailing Address (Street and Number or IZU S. CNCSHCV St. Disposition (Name of cemetery,	Balt, MD. 21,	231 Dity or Town, State			
MOF Pages ent of unt: U	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other Specify	Removal from State cremato	ry or other place)	15,2012 Beltsvi	lle, MD			
Balti permit. Departm Importi injury o	21. Signature of Funeral Service Lice	71 Kmanves 128U						
Physician Medicul examiner	failure. List only one cause on e	ach line. Multiple Injuries	enter the mode of dying, such as cardiac	or respiratory arrest, snock, or near	t Approximate Interval Between Onset and Death			
	or condition resulting in death) Due to (or as a consequence of): b. b. Due to (or as a consequence of): Due to (or as a consequence of):							
red Insit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):						
executed an and al - trans		AMENDED						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burfal - transified in a funeral director, page 2 should be detached for use as the burfal - transified in the funeral director. To Be Completed by Physician/Medical Exhedical Certification: To Be Completed by Physician/Medical Exhedical Certification:	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknow	4 Pregnant at time of death 5	Fetal death 3 Ectopic pregn Other (Specify)	ancy 23d. Date of d	lelivery Day Year			
P.O. E s that the d gned by the e detached by Phy		contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco use contrib	ute to the cause of death? Probably 4 Unknown			
Division of Vital Records, P.O. ral or Attending Physician: The law requires that it is after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacedrification: To Be Completed by F				autopsy pr performed? de	ere autopsy findings available for to completion of cause of eath? Yes 2 No			
ital Finition: Secretification, Be C	examiner?	Hospital: 1 ✓ Inpatient 2 ER/Ou	26.Place of Death (Check tpatient 3 DOA Other Nursi	only one) ing Home 5 Residence 6	Other:			
on of Vi nding Physi th. r: After this re funeral dir	27 Manner of Dooth		ime of Injury 28c. Injury at Work? ND: 1 Yes 2 ✓ No	28d. Describe how injury occurre Pedestrian struck by auto	d			
Division of spital or Attending hours after death. neral Director: After filled in by the funct. Certification:	2 ✓ Accident Investiga 3 Suicide 6 Could no determine	or Rural Route Number, City ay, Greenbelt, MD						
3 Suicide 6 Could not be determined (Specify) Major Road / Highway 3 Suicide 4 Homicide 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as and manner stated 29b. Signature and title of certifier 29c. License number 29c. Date signature and title of certifier 29d. Date signature 29d. Date signature 29d. Date signature 29d. Date signature								
A P S S S S S S S S S S S S S S S S S S	29b. Signature and title of certifier	and manner stated	29c. License number O.C.M.E.	29d. Date signe December 1	d (Month, Day, Year) 3, 2012			
		completed cause of death (Item 23a)						
State	Pamela E. Southall, MD 31. Date filed (Month, Pay Year)	Assistant Medical Examiner 32. Registrar's Signatus	900 W. Baltimore Street, Balt	umore, IVID 21223				
Registra	1 7 7111 /	Chara p. 19						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 13. 70 LANDA ARTSTRONG 20.01 PM Medical 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HAURE DE GRACE METEORIAL HOSAITAL H'ARFORD HARFORD 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕌 Months 0372271926 86 **Director** 220-18-5291 Maryland Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits **Funeral Director** 1 Kyes 2 ☐ No Harford Maryland Aberdeen 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 665 W. BelAir Avenue 21001 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. à ō 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: white 3 XWidowed 4 Divorced Completed Year or Dates th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) homemaker in home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Trincia Elisa Evaristo Bucchi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 665 W. BelAir Avenue, Aberdeen, MD 21001 Barbara A. Mortus (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot once. ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State R.A.Ferris & Company 12/17/2012 West Chester, PA 4 Donation 5 Other (Specify) 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. 21. Signature of Funeral Service License Maryland 21001 Aberdeen, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition SEPTIC Physician/ Medical resulting in death) Examiner ATAINATIONS Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Exami been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the bur Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by OBSTRUCTIVE PULLTONARY DISEASE 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an CIZAHOSIS, ATREAL autopsy performed FIBRILLATION CORONARY ALTERY 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပ 1 Minpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 \square Pending 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Gertifying Nurse Fractioner: To the best of my Impelies 29b. Signature and tiple 29d. Date signed (Month, Day, Year) 21738 DECEMBER. 14.2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALAN SWEAT MAN HMFORD METROLIAN HOSPITAL HAURU DE GRACE 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Décember 735 AM MAHERUNNISSA ABRO 5 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner County Cheneral Hospile Celumbia Howard Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 216-23-Country) Director 1 M 2 D F 16 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other treumetic event, the Medical Example must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Howark 1 Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? Funeral Z Was Decedent of Hispanic Drigin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 🗆 Yes 2 🗷 No Specify: 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surnam ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21732 20a. Method of Disposition 20b. Place of Disposition (Name of Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as pardiac or respiratory shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ob itevans organising I'n eumonia Physician/ Medical resulting in death) *Examiner There sclerolin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine To the Hospital or Attending Physicien: The law requires that the deeth certificate be executed within £4 hours after death.

Or the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Diabetes Hospital or Attending Physicien: The law requires that the deeth certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Lecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie December 15 2012 D32816 E () | aum 30. Name and address of person who completed, cause of death (Item 23a) (Type, Print) 13ack River Neck Road 201-109 31. Date filed (Month, Day, Year)
DEC 1 8 2012

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** oroth ccember /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death Examiner 4b. City, Town, or Location of Death 8. Date of Birth (Month, Day, Age (In yrs. last birthday, 24 Hrs Min. Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 M 2 M Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, If a fredien Examination rediffed at 1 res 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 25 No 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐Yes 21 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify þ 3 ₩ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev ပ NKNOWN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Biad 1ey 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** reboovasa *Medical consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner executed ONGESTIVE and burial-tran Due to (or as a consequence of) the attending physician Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year Pregnant at time of death 5 Other (specify) 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 No 3 Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 2 🗌 No 1 □Yes 2 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Vursing Home 5 Residence 6 Other (Specify) 200 2 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

P.O. Box 68760, Records, Division of Vital

Baltimore, Maryland 21215-0036

that the death certificate be Hospital or Attending Physician: n 24 hours after death.

le Funeral Director: A
bletely filled in by the fu

completely within 7

the the

29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

DEC 18

Baltimore, MD 2/202 nintav 31. Date filed (Month, Day, Year)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

Medical

29a, Certifier

(Check only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ BARBARA MARIE ARES DECEMBER 14,2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death GILCHRIST TOWSON BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days Hours Min (Month, Day, Year) 216-28-3352 Director 1 M 2 TF 81 MAY 10,1931 MARYLAND Usual Residence of Decedent ar than "netural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director BALTIMORE KINGSVILLE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funerai 7 HERITAGE HILLS COURT 21087 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc. should be filed within 72 hours after of end Mental Hygiane. Is marked other than "netural", or 1 Never Married 2 Married Ş Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. If Yes, Give WHITE 3 → Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) EXEC. MEDICAL SECRETARY MEDICAL FIELD Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည VALENTINE C. BALCERAK JEAN DANOWSKI 1 end 2 should b of Heelth end Mei item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOSEPH ARES TIT SON 7 HERITAGE HILLS COURT KINGSVILLE, MD. 21087 or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Pega 1 of Dapartment of Himportant: If its any injury or ot once. cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) SACRED HEART OF MARY 12-18-2012 DUNDALK, MD. 21. Signature of Funeral Service Licer 22. Name and Address of FacilitSCHIMUNEK FUNERAL HOME, NOTTINGHAM, MD. 21236 9705 BELAIR ROAD Part) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition nset and Death Physician/ Machine Medical resulting in death) Due to (or a a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Examine Due to (as a consequence of): Cers signed by the attending physicien and defacted for use as the burial-transit dement Physicisn: The lew requires that the deeth certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregna in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify Month Dav Year Pregnant at time of death 9 Unknown P. 0. Part II. Other significant conditions contributing to death but not resulting in the underlying cauke given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ج</u> Division of Vital Records, within 24 hours after daeth.

To the Funerei Director: After this cartificate has baen si completaly filled in by tha funaral director, pege 2 should I Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy
performed?

Yes 2 No 1 ☐ Yes 2 🗷 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Residence} \) Other (Specify) \(\text{Nu S D UQ} \) ၉ 2 🔲 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred the Hospitai or Attending ☐ Natural 5 Pending FII 9:20 AM 2 Accident Deanby 9 2012 1 ☐ Yes 2 🞾 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

8 10 | Bellon five Towlon MD 4 Homicide determined Assisted living Facility Medical 29a. Certifie ECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 308 December 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar horks

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32. Registrar's signatur

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Khalil Adolemaiu-Bey 2012 40920 Certificate of Death 1- For State Reg. No Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 2325 hrs December 11, 2012 Adolemaiu-Bey Medical Examiner Jabbar Tyrek Khalil 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Harford Upper Chesapeake Health Center 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Foreign Min Days Months Hours 80 Country) MD 04 21 Director 32 220-96-8591 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 1 Yes 2 XNo Abingdon Harford Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number U.S.A. 21001 Way 4700 Witchhazel 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S Funeral 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married 2 X No Yes Specify: Black 4 Divorced If Yes, Give Year 1 Yes 2 No specify. 3 Widowed ≦ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Grid One Company Field Supervisor 1 Y r 12th grade 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Darlene Nixson Be Khalil T. Adolemaiu 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ٩ 4700 Witchhazel Way, Abingdon, md 21001 B Toneka L. Hillmon-Fiancee item 27 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a Method of Disposition timore, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State or other 12/18/2011 Arbutus, Md Important: Arbutus Memorial permit. Page Department Donation 5 Other Specify March Addressof Forlity t Signature of Funeral Service License 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line Death /Medical a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to for as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the attending physician and ed for use as the burial - transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical **AMENDED** UNPENDED Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE Year 23b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Month Day past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>о</u> been signed by 1 Yes 2 No 3 Probably 4 Unknown ğ Completed 24b. Were autopsy findings available Records, 24a. Was an prior to completion of cause of autopsy s certificate has b rector, page 2 sho performed? death? 2 No ✓ Yes 2 No 1 🗸 Yes 26 Place of Death (Check only one) 25. Was case referred to medical director of Vital Be Hospital: 1 Other Nursing Home 5 Residence 6 Other DOA Inpatient 2 V ER/Outpatient 3 this 2 No 1 Yes 28c. Injury at Work? 28d. Describe how injury occurred After the 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27 Manner of Death Certification: 1 V Natural 1 Yes 2 No 5 Pending Division Director: death. Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. within 24 hours after d

To the Fuoeral Direct
completely filled in by 6 Could not be 3 Suicide determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registra

31. Date filed (Mon

egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

OCME

Donna M. Vincenti, MD _ Assistant Medical Examiner

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

December 13, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 7,8 per fh g935 1-8-13 vt. State of Maryland 7 Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 03:25 AM WEIVIN 3013 Secombe Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore NA Hospita DIMOR pwore 6. Sex If Unde 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Hours Min (Month, Day, 1951 214-58-7963 **Director** 1 🛛 M 2 🗆 F 61 July 2,1961 Maryland Usual Residence of Deceden 28a-f show 10a. State 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 X Yes 2 □ No Maryland N/A Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21223 31 North Smallwood Street United States death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Black 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Security Guard Security should be filed with n and Mental Hyglen 7 is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev ည John Rufus Bullock Catherine Staton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1721 Cattail Woods Lane, Woodbine, Maryland 21797 Catherine Wooten / Mother 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 12/18/2012 | Baltimore, Maryland Signature of Euneral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland Inc 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition 6000 COCCUTOTTE ayears Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physiclan and Cause (Disease or injury for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 4 ☐ Pregnant
9 ☐ Unknown signed by the sild be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an director, page 2 performed? Yes 2 No death? 1 Yes 2 No 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural injury 5 Pending Investigation Accident 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1285 9019 who completed cause of death (Item 23a) (Type, Print) HIV 30. Name and address of person

State Registrar 5 CC filed (Month, Day, Ye.

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32. Registrar's

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Sicot

Beltmore

12-09368 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Richard Brizendine 2012 40922 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Time of Death Richard Wayne Brizendine Month Day December 9, 2012 Medical Examiner 0345 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deatl Good Samaritan Hospital **Baltimore** 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** 7. Age (In yrs. last birthday) Director 214-84-7053 Months Days Hours Foreian Nov 22, 1960 52 country) Maryland 1 XM 2 F Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Parkville 28a-f show Maryland Baltimore 1 Yes 2 X No hours after death with the Maryland rector 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 21234 U.S.A. 靣 2605 Wycliffe Road tems 23a Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 2 X No Yes 4 X Divorced If Yes, Give Year Specify.White 3 Widowed 1 Yes 2 X No specify: <u>۾</u> or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within 72 h nent of Health and Mental Hygiene. nnt: If item 27 is marked other than "n Elementary/Secondary (0-12) College (1-4 or 5+) fother than " Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 7 2 self employed sales Com 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) 8 Edward Brizendine Evelyn Manko 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberley Burkhardt 7113 Wardman Road Stoneleigh, MD 21212 sister 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 12/13/2012 Baltimore, MD Metro Crematory 4 Donation 5 Other Specify: è 21. Signature of Funeral Service License 22. Name and Address of Faylittchell-Wiedefeld Funeral Home, In 6500 York Road Baltimore, MD 21212 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** 23a, Part I. Enter the disease Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death **HEMOPERICARDIUM** Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): RUPTURED MYOCARDIAL UNFARCTION Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and DISEASE Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Physician/Medical UNPENDED AMENDED ned by the attending physician detached for use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Day Year past 12 months? 2 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 V No 3 Probably 4 Unknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has performed? death? certificate ✓ Yes 2 No ✓ Yes 2 No director, 25. Was case referred to medical æ 26.Place of Death (Check only one) Other Nursing Home 5 Residence 6 Other: this 1 Yes



To the Funeral Director:

After

the

Certification:

Medical

Mary G. Ripple MD Deputy Chief Medical Examiner 31. Date filed (Month) State Registrar

27. Manner of Death

5 Pending

6 Could not be

Investigation

determined

1 XX Natural

2 Accident

3 Suicide

4 Homicide

29b. Signature and title of certifie

(Check only

32. Registrar's Signature

28a. Date of Injury (Month, Dey,Yeer)

and manner stated

of person who completed cause of death (Item 23a)

arked

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc

Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Wedlcal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28c. Injury at Work?

29c. License number

O.C.M.E

900 W. Baltimore Street, Baltimore, MD 21223

1 Yes 2 No

28d. Describe how injury occurred

or Town, State)

28f. Location (Street and Number or Rural Route Number, City

December 9, 2012

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40923 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 15, **JOSEPH BOHASKA** 2012 5:55A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign (Month, Day, Year) 218-09-0308 92 Director 1**X**XM 2 □ F 03/22/1920 Maryland 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore Towson 1 Yes 2 XXVo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8214 Burnley Road 21204 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1XX Yes 2 No WW]]

If Yes, Give Black, White, etc. ۾ 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mantal Hygiana. is marked other than College (1-4 or 5+) Elementary/Secondary (0-12) Supervisor Utility å 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should ba fi of Health and Mantal Itam 27 is marked ည John Joseph Bohaska Anna Virginia Hartman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucy G. Bohaska Wife 8214 Burnley Road Towson, Maryland 21204 20b. Place of Disposition (Name of cemetery, crematory or other pl 20a. Method of Disposition Date 20c. Location - City or Town, State Department of I 1 🕅 Surial 2 🗆 Cremation 3 🗆 Removal from State Injury or Druid Ridge Cemetery 12/19/2012 Pikesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) gnature of Funeral Service Lice 22. Name and Address of Faction it chell-Wiedefeld Funeral Home Inc any 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Hyelodysplastic disorder Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): attanding physician and for use as tha buriai-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Day signed by tha a id ba datached f 9 Unknown 9. Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records, Dementia Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 1 No or Attending Physician: of Vital diractor, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Hrsm c funarai Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) 5 Pending Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte complately filled in by the fun 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D007063K 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) aura Patel Cha Nes sute 4605 Bulhmore, ND 212,9 01 31. Date filed (Month, Day, Year) State 8 2012

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Douglas McAndrew Brooks, Sr. : 00 P M 2012 Medical Dec 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 4b. City, Town, or Location of Death Harford Havre De Grace 515 Warren St. If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Davs Hours Min. (Month, Day, Year) 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 216-52-9920 Director 1 XX M 2 - F 64 Dec.5,1948 MD Usual Residence of Decedent in than "natural", or items 23a or 28a-f ahor The Medical Exercises must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Harford Havre De Grace 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21078 515 Warren St. Apt. 10 filed within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married 2 1 ☐ Yes 2 🔀 No Specify. Completed 3 Widowed 4 Divorced Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Construction Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be filed to the filed of Health and Mental Hitem 27 is marked ot Richard Brooks LINK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 650 Yorkshire Drive Edgewood, MD 21040 Latonia Brooks/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, permit, Page 1 a Department of H Important: If Ite any injury or ott 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Bayview Crematory 12/19/12 4 ☐ Donation 5 ☐ Other (Specify) Dundalk, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Chatman-Harris Funeral Home 4210 Belair Road Baltimore, MD 21206 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ao Nonsmall Lung Conce. Physician/ disease or condition ONG Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to for as a consequence of: signed by the attending physiclan and d be detached for use as the burlal-transIt Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate ba IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Pregnant at time of death Day Year g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by The law requires 1 Pres 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate Yes 2 Hospital or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1. Natural 5 \square Pending injury To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HESAPONIU 1610 31. Date filed (Month, Dav. Vear State Registrar

DHMH 17 Rev 06-2011

Maryland 21215-0036

Box 68760

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical 201 Examiner 4a. Facility Name (if not institution, give street and nymber) 4b. City, Town, or Location of Death 4c. County of Death Ba MOY 9. Birthplace (State or Foreign Country) White Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 088.48.21 Months Hours Min (Month, Day, Year) Director 1 - M 2 - F inc dom 1 end 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10b. County traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No IMAYE Mort 10e. Street and Number 10f. Zip Code 10g. Çitizen of What Country? Funeral Kina nmor down 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes Giv Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Sance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Nymber or Rural Route Number, City or Town, State, Zip Code) 91411 ute 1 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of permit, Page 1 e Department of H Important: If ite 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Dec. 19,7201 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility any -86 212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition BREAST Priysician/ META STATIL Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): sician and burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The lew requires that the death certificate be Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Month Dav 5 Other (specify) signed by the at Id be detached for Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, Completed 1 ☐ Yes 2 💆 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s has autopsy perform death? After this certificate Yes 2 N 1 ☐ Yes 2 ☐ No Division of Vital 24 hours after death.
Funeral Director: After this certificately filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 N Residence 6 Other (Specify) 1 🗌 Yes 2 📉 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred 1 X Natural 5 Pending 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) D18350 12 17/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Falls Ro. 1075 いってれていいしも MS 21093 TETTIN

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

8

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dec Day 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ow 70S rimore 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth Birthplace (State or Foreign Country) Days Hours Min (Month, Day, Year) Director 1 **№** M 2 🗆 F 6 Virginia 28a-f show 10c. City, Town or Location 10a. State 10b. County filed within 72 hours after death with the Maryland the Madical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No More ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? , or items 23a Funeral 9 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. Š 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2-No Specify "natural", Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) Page 1 and 2 should be file ment of Health and Mental ant: If item 27 is merked o wood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maaa or other 20a. Method of Disposi 20b. Place of Disposition (Name of cemetery, crematory or other permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) PC-15,2012 M01442 21. Signature of Funeral Service Licensee 22. Name and Address of Pacility 23a. Part 1) Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirat of arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ MECNIC OBSTRUCTIVE disease or condition resulting in death) PULMONNEY DARC Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician end I for use es the burial-trensit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month 5 Other (specify) ate has been signed by the spage 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobageo use contribute to the cause of death? ģ Records. Be Completed 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed' After this certificate Yes 2 🛮 1 Tyes To the Hospital or Attending Physician: "within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital 26. Place of Death (Check only one, Hospital: Other: မျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident 1 ☐ Yes 2 ☐ No Investigation ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier The deficial Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Jacqueline Wooden Beatty December 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Director 579-72-3423 1 M 2 X F 60 Jan. 13, 1952 Washington, DC 28e-f shov 10a. State 10b. County 10c. City, Town or Location Director event, the Medical Examiner must be notified 1 X Yes 2 □ No Waldorf MD Charles 6 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 236 Funeral 10449 Starlight Place 20603 USA Items death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or 1 Never Married 2 Married Completed by 1 Yes : 72 hours efter 2**X** No Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: Black 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other then ' Elementary/Secondary (0-12) College (1-4 or 5+) 5+<u>Elementary School Teacher</u> Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ be Lillie R. Williams 0ne11 Wooden Pege 1 end 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health aitem 27 i 10449 Starlight Place, Waldorf, MD 20603 Charles Beatty/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Pege 1 e Depertment of H Importent: If ite eny Injury or otl Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 12/19/2012 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility J.B. Jenkins Funeral Home, narmany 7474 Landover Road, Hyattsville, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Cardio Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner End Stage Sarcoidosis Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examir physicien and s the burlal-transit Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 ettending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Year 4 Pregnant at time of death 9 Unknown signed by the ef Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an ours after death. erel Director: After this certificate has I filled in by the funeral director, page 2.9 autopsy 2 X No 1 Yes 2 No 1 TYes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖺 No ည 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours a To the Funeral Completely filled Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 008547 December 13, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Gebremedhin Yohannes,

Date filed (Month, Day

MD

1500 Forest Glen Road, Silver Spring, MD 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Gloria Anne Baldauf 18,2012 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore County Gilchrist Hospice Center Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 220-40-9720 Director 1 □ M 2X F June 29,1943 Baltimore.MD. 69 Yrs. Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland 10b. County Director 1 ☐ Yes 2 K No Maryland Baltimore County Phoenix 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 12833 Stone Eagle Road 21131 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify If Yes. Give 3 Nidowed 4 Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done of life, DO NOT use retired) during most of working (Specify only highest grade completed) al Hygiene. I other than " College (1-4 or 5+) Elementary/Secondary (0-12) Own Home Home Maker 12 N/A Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If tem 27 is marked oth any Injury or other traumatic event Once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anne Mary Geirsch ٩ Thomas Garos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fallston, Maryland Mr. Christopher R. Baldauf / Son 1910 Coachman Court Baltimore, 20c. Location - City or Town, State Harford County 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State Evans Funeral Chapel and Wednesday, Dec. 19,2012 Atternation 5 Other (Specify)

Cremation Services, Inc. Dec. 19,2012 | Forest Hill, Maryle of Funeral Service Funeral Services Funeral and Cremation Center, P.A. 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 21. Signatur Lic.#M00677 t 1. Enterene disease, or confailure. List only 2325 York Road Timonium.Maryland plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final disease or condition Herin Physician Medical resulting in death) Due to (r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Physician/Medical Examiner Due to (or as a consequence of): sician and burial-transit The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Box 68760 for use as the yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of doots IF FFMALE: 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy 3 in the past 12 months? Day Month Pregnant at time of death signed by the at Id be detached for 1 Yes 2 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autops, performed. 2 No has 1 ☐ Yes 2 ☐ No After this certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence Hospital 1 🗌 Yes 2 X No ဍ 1 Inpatient 2 ER/Outpatient 3 DOA 6 X Other (Specify) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury 28d. Describe how injury occurred Certificate: Natural (Month, Day, Year) 5 Pending Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License numbe 18

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State Registrar AUN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 7:40 A M June Ellen Bell December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore TOWSON Gilchrist Center 8. Date of Birth (Month, Day, Year) June 01, 1926 9. Birthplace (State or Foreign Country)
Georgetown, DC If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 220-12-7630 Director 86 1 [] M 2 X F than "netural", or Items 23e or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 No Glen Arm Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21057 United States 11630 Glen Arm Road . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2XXNo If Yes, Give φ Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home a 1 and 2 should ba filed wit of Health and Mental Hygie of Item 27 is marked other r other treumatic event, the Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Margaret M. Berigtold Horace Buckley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2931 Moores Road Baldwin, Maryland 21013 Dorothy Brazil (Daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or oth
Parkwood Cemetery 5 permit. Paga 1
Department of
Important: If It
any Injury or o 1 X Burial 2 Cremation 3 Removal from State December 20, Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services—Parkville
8800 Harford Road Parkville, Maryland 21234 21. Signature of Juneral Service Licensee Evans Funeral Chapel & Cremetto 8800 Harford Road Parkville, M

23a. Part 1. Enterthe disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sersi's Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) or Attending Physician: Tha law raquires that the daath cartificate be axacuted ettanding physician and for use as tha burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day signed by tha el 1 Yes 2 9 Unknown Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Muocardial infavetion Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown To the Hospital or Attending Physician: The law require within 24 hours after clearl.

To the Funeral Director. After this certificate has been sit completely filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 🗆 No 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) **Division of Vital** a Other:
4 Nursing Home 5 Residence 6 Other (Specify) Hospico 2 No 1 Yes |요 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of sertifier 29d. Date signed (Month, Day, Year) 12/16/12

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State Registrar Pate

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Baltmore, all 21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nthony Joseph	Вга	1- For State	tate of Maryla	-	artment of rtificate of		and	Menta	al Hy		g. No. 20	12	4093	
Physicia		Registrar 1. Decedent's Name (First, Mide	dle,Last)			,	-		2	2. Date of Deat	h		Time of Death	
ledical Exami	iner	Anthony Jo								December	ember 12, 2012 1430 hrs			
		4a. Facility Name (if not instituti 31 Serpens Court	ion, give street and nu	imber)	4	b. City, Tow Roseda		ocation of	Death		4c. County of Baltimore		,	
Funeral		5. Social Security Number	6, Sex	7. Age (In yrs.	last birthday)	If Under		if Under:	24Hrs.	8. Date of Birt	h (MM/DD/YYYY)			
Director		217-31-0055	‡ XX M 2 F	21	Yrs.	Months	Days	Hours	Min.	1	24, 1991	Foreign	y) Maryland	
		Usual Residence of Decedent	r							2			" I ELLY ICE	
/ any		10a. State 10b. County		4	, Town or Location	on							d. Inside City Limits	
Aaryland 28a-f show 1 at once.	ō	_	imore	Ove	erlea								Yes 2 No	
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number				10f. Zip Co 212(10g. Citizen of What Country? United States				
ith the 23s o		3 Willow Ave		al re la n	0 140 111				0.10					
ath wi	Funeral		Married Armed Fo			s Decedent es, specify (cify Yes or No- lican, etc.)	14. Race - White,		Indian, Black,	
fter de		3 Widowed 4 D	1 Yes	2 X No	1	Yes 2	No	specify:			Specify:	Whit	e	
hours afte "natural", Examiner	d by	15. Decedent's Education (Sp	ecify only highest grad	de completed)	16a. Decedent	t's Usual Oc ost of workin					16b. Kind of Bus	iness/Indu	stry	
16 n 72 h	lete	Elementary/Secondary (0-12) College (1	-4 or 5+)		lumbe		O NOT U	se reme	u)	Plumb	ing		
OO3 withi	Completed	1 0 17. Father's Name (First, Middle	a last)					Mother's	Name /	First Middle M	faiden Surname)			
215-0036 be filed within 7 ntal Hygiene. riked other than	Be C	Raymond Jo		t			1				eth Isr	ael		
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shomatic event, the Medical Examiner must be notified at once	To E	2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)										Code)		
s, MD 21215-0036 and 2 should be filed within 72 teath and Mental Hygiene. tem 27 is marked other than traumatic event, the Medical		Mary Elizabet	h Israel (ryland 2			
ore, of Hea If ite		20a. Method of Disposition 1 Burial 2 X Crematic	on 3 Removal fr		Place of Disposi crematory or oth ans Funera					Date	20c. Location - (
Baltimore, permit. Pages 1 at Department of He. Important: If ite		4 Donation 5 Other S					A:	ir 📗	20	nber 16, 12			, Maryland	
Bal permi Depar Impo	Plumber Plumbing Plumber Plumbing Plumb									es-Pari	kville			
Physician		23a. Part I. Enter the disease of	or complications that co	aused the death	n. Do not enter th							t A	pproximate Interval	
Medical ≟xaminer		failure. Listo y one caus Immediate Cause (Final diseas	36 . 7 3	ne Into	xicatio	n						1	Between Onset and Death	
_Agninici		or condition resulting in death)	Due to (or as a	consequence o	of):									
,	e	Sequentially list conditions, if any, leading to immediate	b Due to (or as a	consequence of	of):							_		
	miner	cause. Enter Underlying Cause (Disease or injury that initiated	C		6									
nted d ansit	Exa	events resulting in death) Last	d.	consequence of	or):									
be executed sician and urial - transi	dical	X UNPENDED	AMENDED2	23a,27,2	8a-f,pe	r me,	g935	5 1-9	-13	sm				
Box 68760 death certificate b the attending physical of for use as the bu	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in		outcome of preg		al death	3 [Ectopic p	recnan	cv	23d. Date of o	lelivery Day	Year	
th cert	icia	past 12 months? 1 Yes 2 No 9 Ur	dunaum -	ant at time of de	agth _	ner (Specify) _					,		
Bo he dea y the a	hys	Part II. Other significant cond	9 Onkno		ensulting in the co	adarking as	una aiu	on in Dod		220 Did to	bacco use contrib	uto to the	nause of death?	
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physompletely filled in by the funeral director, page 2 should be detached for use as the b	Ď		contributing to	death but not i	esulang in the di	nderlying ca	iuse giv	eninrait			2 ✓ No 3			
of Vital Records, ng Physician: The law require the continue has been sineral director, page 2 should	Completed									24a. Was a			y findings available eletion of cause of	
Recol	mo									perform		ath? Yes	2 No	
tal Recien: The	BeC	25. Was case referred to medic examiner?				26.		f Death (C	heck or	'				
Physic r this	P	1 ✓ Yes 2 No		npatient 2	ER/Outpatient						Residence 6		ene	
28b. Time of Injury 28c. Injury at Work? 28d. Describe how (Month, Day, Year)								ow injury occurre	u					
Division tal or Attendir rs after death. al Director: A	icat	2 Accident Inve	estigation Id Iz		fd 14:25 ome, farm, stree	o pm				8f. Location (S	treet and Number	or Rural F	Route Number, City	
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	Odicido	uld not be ermined (Specify)	Single	Family	Home			- 1	or Town, St Rosedal	ate) 31 Ser	pens	Ct.	
e Hosp 124 ho e Func	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
To the within To the compl	Medical	one) 2 Medical Ex 29b. Signature and title of certif	and manner s		and/or investigati		inion, d		irred at f	ne time, date a				
	~	200. Signature and title of certif	4/ 40				D.C.M.				29d. Date signed December 1			
		+apilly sidney, my												
nd		30. Name and a dress of person	n who completed caus	se of death (Item	n 23a)			· - -				-, -, -, -		
Ø		30. Name and a dress of person Pamela E. Southall,	·	se of death (Item Medical Exa	,				Baltim	ore, MD 21				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 20 | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2 Year **Physician** 410AM Balling 2012 George Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore FRANKLIN Square Hospital Rosedale If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)

October 27, 1946 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months 1**X**M 2□ F 212-44-1230 Director 66 Maryland Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Madical Examinar must be notified at 1 ☐ Yes 2 XNo Directo Maryland Baltimore Edgemere 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21219 7848 North Cove Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 □Yes 2 No 9 Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 2 years Medical 12 years Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental Ruth Bass George B. Balling Sr. Injury or other traumatic ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 and 2 and 2 and 2 and 2 and and and and 27 ls any injury or other trau once. Patricia Balling wife 7848 North Cove Road, Edgemere, Maryland 21219 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition December 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MAryland 20, 2012 Oak Lawn Cemetery 21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. tho 7110 Sollers Point Road, Dundalk, Md. 21222 omplications that caused the deal ont enter the mode of dying, such as cardiac or respiratory arrest, may one cause on each line. 23a. Part 1. Enter the disease, of a shock, or heart failure. List of Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** multiple Mycloma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) 9 Unknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an certificate has be rector, page 2 s autopsy performe 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one)

Division of Vital Records, P.O. Box 68760 within 24 hours a

To the Funeral I

completely filled

5-0036

2121

Maryland

Baltimore,

2112

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Samer

8 2012

Ahmad

Jomes Alahad

29c. License number

400

9000 FRANKLIN SQUARE DR Balto Md 21237

29d. Date signed (Month, Day, Year) 12-17-2012

and manner stated.

2. Registrar's Signature

Ahmad

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) &

Alawad

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ BUGARIN HASE 6:40 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner OF MARYLAND MEDICAL CENTE BALTIMORE UNIVERSIT If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month. Dav. Year Months Days Hours Country. Director 1 DM 2 DF in then "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State filed within 72 hours after death with the Maryland Director 1 Nes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral USA 21085 1€. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 🗆 Yes 2 🖼 No If Yes, Give Year or Dates Specify 3 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) INFAN permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle Last) မ 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Routé Number, City or Town, State, Zip Code) 21085 Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 14/200 . Signature Guneral Service Licen radley-ASKHON 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arfest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Respuratory Immediate Cause (Final Physician/ MADER HUSION disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner racheomalacia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): attending physician and for use as the burial-transit omplete or Attending Physicien: The law requires that the death certificate be executed the attending physician Physician/Medical Irisom. P.O. Box 68760 IF FEMALE: f yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy 3 in the past 12 months?

1 Yes 2 No
9 Unknown Month page 2 should be detached g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autoosy performed? Ves 2 No within 24 hours after death.

To the Funeral Director: After this certificate to completely filled in by the funeral director, pag 1 ☐ Yes 2 🛛 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Natural 5 Pending Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the cause of examination and/or inventionation in manner as stated. Medical the Hospital 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State

Registrar

DHMH 17 Rev 06-2011

29b. Signature and title of certifier

CHINAZOWNEN

31. Date filed (Month)

menuru

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MBBS

32. Segistrar's Signature

D0072093

SOUTH GREENE STREET, BALTIMORE

29d. Date signed (Month, Day, Year)

	ype or Print in Black Ir		•		
1 _ State	State of Maryland / Depa	artment of Health and tificate of Death		2012	40933
Registrar 1. Decedent's Name (First, Middle, Last)	OCI	uncate or beaut	2. Date of Death	No.C U I C	3. Time of Death
Physician/ Medical Lola Louise Brant			Month December	Day Year 14. 2012	5:17 A. M
Examiner 4a. Facility Name (if not institution, give stre	reet and number)	4b. City, Town, or Location of Deat		4c. County of Death	
Senator Bob Hoope: 5. Social Security Number 6. Sex		Forest Hill		Harford	
100 25 1000	7. Age (In yrs. last birthday) M 2 🔀 F	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthp Coun	place (State or Foreign try)
Usual Residence of Decedent	79		July 30,	1933 Mis	souri
purify 10a. State 10b. County	10c. City, Town or Loc			1	0d. Inside City Limits
Maryland Harford 10e. Street and Number	Bel Air	10f. Zip Code	10-	C'ai	1 ☐ Yes 2 🔀 No
Donot pure marked by the marke	7,11		10g.	Citizen of What Cour	ury ?
Table 1812 Barrington 7	2. Was Decedent Ever in U.S. 13. V	Vas Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - Americ	an Indian,
1 Never Married 22 Married	1 ☐ Yes 2X No	Yes, specify Cuban, Mexican, Puerl Yes 25 No Specify:	o Hican, etc.)	Black, White, e	etc.
S1213 S217	Year or Dates.			Specify: Whi	
(Specify only highest grade	completed) (Give k	lent's Usual Occupation kind of work done during most of wo DNOT use retired)	rking 16b	o. Kind of Business/Ind	dustry
Specify only highest grade (Specify only highest grade) 12 12	College (1-4 or 5+)	emaker		Own Home	
TIC TO THE WEIGHT OF THE WIND		18. Mother's Na	me (First, Middle, Maid	len Surname)	
Alva (nmn) Newkirk			Nell Renni		
The state of Disposition 17. Father's Name (First, Middle, Last) Alva (nmn) Newkirk Alva (nmn) Newkirk 19. Informant's Name/Relationship (Type, John H. Gregory / 20a Method of Disposition	700: 1110	g Address (Street and Number or Ru			1
	20b. Place of Dispos			SEL AIT, M Location - City or To	
1	emoval from state Rosehill	natory or other place) SVCS. LLC 12/1	L7/2012 E	Bel Air, M	arvland
20a. Method of Disposition 1			1cComas Fur		
		317 Cokesbury Roa	ad, Abingdo		
23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one of	cations that cause the death. Do not ente cause on each line.	r the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
Physician/ Immediate Cause (Final disease or condition resulting in death) a.	ALZHEIMERS DISEASI	Ε			Onset and Death
Examiner	Due to (or as a consequence of):				
Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
<u> </u>	Due to (or as a consequence of):				
Interpretation of the following of the f					
IF FEMALE: 23b. Was decedent pregnant 23c	c. If yes, outcome of pregnancy	1		23d. Date of delive	erv
in the past 12 months? 1 ☐ Yes 2 ☒ No	1 Live Birth 2 Fetal death 3 Pregnant at time of death 5 Unknown	Consideration of the control of the			Day Year
A See a popular that the design of the desig		ndodrine serve show in Deat t		<u></u>	
Age Cords, P.O. Be are the law requires that the dea the has been signed by the graph of the dead of the dead of the law requires that the dead of the law requires that the dead of the law requires that the dead of the law requires that the dead of the law requires that the dead of the law requires that the dead of the law requires the law requ	mouning to death but not resulting in the til	ndenying cause given in Part I.	23e. Did tobaco	co use contribute to th	e cause of death?
Drds require should be a shoul			24a. Was an	1 -	·
le CC on le law			autopsy performed	? death?	osy findings available inpletion of cause of
The second secon		26. Place of Death (Che	1 ☐ Yes 2 🔀	No 1 ☐ Yes	2 U No
examiner?	spital: 1	Other		6 X Other (Specify)	Hooper Hous
27. Manner of Death 1 XX Natural 5 \sum Pending	28a. Date of injury (Month, Day, Year) 28b. Time of injury	28c. Injury at work?	28d. Describe how in	jury occurred	
To constitution of the property of the propert	28e. Place of Injury - At home, farm, stre	M 1 Yes 2 No	000 1 1:	111 1 5 1	
Division of Vital Records, a after death. a after death. a filter this certificate has been signed and by the funeral director. After this certificate has been signed and by the funeral director, page 2 should be conditioned. 25. Was case referred to medical examiners. 1 Natural 2 Death 27. Wanner of Death 1 Natural 5 Dending Investigation 28. Machine the funeral director page 2 should be determined.	building, etc. (Specify)	et, factory, office	City or Town, Sta	and Number or Rural ate)	Houte Number,
Q is the first of	ian: To the best of my knowledge, death o	ccurred at the time, date and place,	and due to the cause(s	s) and manner as state	ed.
DIVISION OF THE PROPERTY OF T	r: On the basis of examination and/or investi Practitioner: To the best of my knowledge,	death occurred at the time, date and p	place, and due to the car	use(s) and manner as s	tated.
230. Signature and title of certifier	n an AD. 10	29c. License number) a 29d.	Date signed (Month, L	yay, Year)
30. Name and address of person who com	pleted cause of death (Item 23a) (Type, P	nint)		2111	'X
TRACIE L. MORGAN,	CRNP 2300 DULANES	Y VALLEY RD. TIM	ONIUM, MD	21093	
State 31. Date filed (Month, Day, Year) Registrar 1	32. Registrar's Signature				

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Brackins sevald wayne Month 09:45 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death UPPer ChesaPeake Hospital Bel Air Harford 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Birthplace (State or Foreign Country) Days 218-38-3548 Hours Min. 1[¥] M 2 □ F Director 72 Feb. 29, 1940 Maryland 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, <u>the Medical Examiner must be notified at</u> 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Harford Edgewood 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1709 Pulaski Hwy 21040 **USA** 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 Xes 2 No 1 Never Married 2 Married ģ permit. Page 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar any injury or other traumatic event, the Medical Exar any once. 1 ☐ Yes 2 No Specify: 3 Divorced 4 Divorced Completed White Year or Dates Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
Motor Cycle (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Sales & Repair Owner/Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Wayne Brackins Ivera Mary Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1709 Pulaski Hwy, Edgewood, Maryland 21040 Elizabeth M. Brackins / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Rose Hill Scvs, LLC Bel Air, Maryland 12-19-2012 f Funeral Service Lice 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mmediate Cause (Final Heen Physician/ Onset and Death Ougestive disease or condition Medical resulting in death) Due to (or all a consequence of): Examiner Starpe Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of, that the death certificate be executed Stag liver resulting in death) Last Due to (or as a consequence of): Physician/Medical EX-31004 Box 68760 IF FEMALE: yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Day 9 Unknown P. 0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ś 23e. Did tobacco use contribute to the cause of death? Records, 3 Probably 4 ☐ Unknown Completed 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes 2 12 No Other: ပ္ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 6 Could not be I hours after death uneral Director: / Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital o within 24 hours af To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Detailing Prijstolan. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) (Mulmy D0073048 Kowmy. 12/17/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 Upper Chesapeake Dr. Bel air, md 21014 Muhannad Kanbour MO

State Registrar

SOC = 2

32. Registral's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4a/Facility Name (If not institution, give street and number) Examiner 000 NUUV 1 49 HOBE 0 GK If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 28 9. Birthplace (State or Foreign . Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🗗 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 28a-f show ral", or items 23a or 28a-f shov 1 ☐ Yes 2 ☐ No my Baltimore Baltimore Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21207 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Matus 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 2 Specify: 3 Widowed 4 Divorced "natural", Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working iife. DO NOT use retired) 16b. Kind of Business/Industry th and Mental Hygiene.
7 is marked other than "natur traumatic event, the Medical miller Bro. Ford Elementary/Secondary (0-12) College (1-4or 5+) Salus MAN 18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last) millhorse Mas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nant's Name/Relationship (Type. Print) Batto. MD. 21207 Department of Health a Important: If item 27 is any injury or other tra once. 1009 LellI of Health and 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 18/12 Balto, mo remation Ctr 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Vaughl Ba 1+0. mD 21229 5151 Balto. Nat'L 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 90 **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 2 X No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 3 Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier person who completed cause of death (Item 23a) (Type, Print) 30: Name and address of KAZIOW Brows1 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 20:55 PM **Physician** DALE BRUMBAUGH DECEMBER 12, 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days **Funeral** Hours 1 XM 2 □ F Mar 5, 1924 Indiana 309-16-6260 88 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location or 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2X No Director Parkville MD Baltimore 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number ō "natural", or Items 23a or dical Examiner must be a United States 21234 8800 Walther Boulevard #4514 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 X Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: \$ Caucasian 3 N Widowed 4 Divorced WWII Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education the Medical (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Naval Officer U.S. Navy 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be find and Mental His marked ot Be Baker Essie John Calvin Brumbaugh traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health as Important: If Item 27 is any injury or other trau Nancy R. Walker / Step-Daughter 807 Chestnut Glen Garth Towson, MD 21204 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Final Journey Crematory 12/18/2012 Woodbine, Maryland 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licens 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** STROKE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): executed iclan and burial-trans Due to (or as a consequence of): attending physiclan Box 68760. Physician/Medical certificate be as the t IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Day in the past 12 months? funeral director, page 2 should be detached for 4 Pregnant at time of death 5 Other (specify) 2 No 9 Unknown P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ of Vital Records, 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 2 No 26. Place of Death Check only one or Attending Physician: 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2X No 1 inpatient 2 ER/Outpatient 3 DOA မ 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: Division 24 hours after death. Funeral Director: After 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be filled in by 4 T Homicide Hospital Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier within 24 hou To the Funel completely fi Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only one) To the h 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DECEMBER 12,2012 Madeline hears RESODO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

MADELINE LEONG, MD 31. Date filed (Month, Day, Year)

32. Registrar's Signature

ORIGINAL

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ lda 1-U1/6V Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Oak Crest Care Center Parkville . Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign Hours Min March 28,1928 County aryland Director 213-24-7515 1 🗆 M 2 🗓 F 84 Vrs or 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits with the Maryland Director be notified NC. 1 Yes 2 No Wake Cary 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 109 Hemingford Grey Ct. 27518 U.S.A. items death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black White etc 'natural", or Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 **X**No within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other than " Baltimore Co. Elementary/Secondary (0-12) College (1-4 or 5+ permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Guidance Counselor Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ၉ Evelyn Barnes Todd Ford Important: If item 27 is m any injury or other traum. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philip Todd Benson 109 Hemingford Grey Ct. Cary NC. 20b. Place of Disposition (Name of cemetery, crematory or other place) Dec 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 17,2012 Manchester, MD. Faiths Crematbry 21. Signature of Funeral Service Licensee 22. Name and Address of Facility EckhardtFuneral Chapel P.A Thelo 11605 Reisterstown Rd. Owings Mills, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ melin on a disease or condition resulting in death) Medical Due to (or as consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter onderlying Cause (Disease or injury Due to (or as a consequent e of) burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical しいision of Vital Records, P.O. Box 68760 as the attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for 1 in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Year 1 Yes 2 the a detached g | Linknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by be 1 Yes 2 No 3 Probably 4 Unknown filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ろうろう 24a. Was an After this certificate has autopsy perform Hospital or Attending Physician: The Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: ပ္ 1 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical within 24 hou

To the Fune

completely fi 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature, and title of cettifie 29c. Licer 29d. Date signed (Month, Day, Year) 30. Name and/address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar 32. Registrar's S

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Physician		Registrar 1. Decedent's Name Michael					Cer	tificate	of D	eath_		2. Date of I	Death	525		3. Time of De 11:32 A	
Medica Examine	r	4a. Facility Name (if Future Ca	not institution	sing Home	ber)			4b. City, T	imor	e			4	4c. Coun	ty of Deat	h	
Funeral Director		5. Social Security N 219-68-12 Usual Residence of	216	6. Sex 1 ▲ M 2 □ F	7. Ag		48 Yrs.	If Under Months	1 Year Days	If Unde Hours	Min.	8. Date of the sept 1	Birth D <i>ay, Y</i> ea <i>r</i> 8	964	g. Biri Mary	hplace (State or Fo Intry) Land	oreign
th the Maryland 3a or 28a-f show t be notified at	rector	10a. State Maryland	10b. County				y, Town or Lo	cation								10d. Inside City L	
filed within 72 hours after death with the Maryland al Hygiene. 4 other than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at	Funeral Director	10e. Street and Nur 952 Eltor 11. Marital Status		12. Was Dece	dent (Ever in 11 S	12.1	10f. Zip	4	enanic O	rigin? (Sn.	ecify Yes or N	Uni	ted	Stat		
permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must be once.	2	11. Marital Status 1 X Never Marr 3		Armed For	ces? 2 X 2	No	1	f Yes, specif	fy Cubai	n, Mexica	an, Puerto	Rican, etc.)	0-		ack, White		
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iit. Page 1 a intment of h intrant: If ite njury or ot		20a. Method of Disp 1 X Burial 2 4 ☐ Donation 21. Signatur of fu	Cremation 5 Cother (State	C		rk Ce	nete mete	ry	ec.		2 Ba	ltin	nore,	Town, State Maryland	
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Physician/ Medical Examiner		Immediate Cause disease or condition resulting in death)	(Final on	only one cause on each	76	e. } \$ T1 a consequ	ROIN uence of):	17 <i>€</i> 5	TIN	AL	B	LEE	>			Interval Betwee Onset and Dea	
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ia e	_	that initiated event resulting in death)	ts	c. Due to (or as	a consequ	uence of):										
tth certific ittending p or use as	Pnysician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 [9 ☐ Unknown	months?	23c. If yes, out 1 ☐ Live 4 ☐ Pregr 9 ☐ Unkn	Birth nant a	2 Feta	al death 3	Ectopic p		;y			_		Date of de	livery Day Yea	r
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To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completed filled in by the fi	Medical	29a. Certifier Check only one)	2 Medical	g Physician: To the b Examiner: On the bas g Nurse Practioner:	is of e	examination	n and/or inves	stigation, in n	ny opinio	on, death	occurred a	at the time, da	e and pla	ace, and o	due to the	cause(s) and manne	er stated.
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JOHN		30, Name and addr	Fess of person	who combleted caus			1 23a) (Type, I	Print)	ME	Ri	Rur	V Ro	#	E	E	SEX, M	>
State Registra		31. Date filed (Mon	th Day, Year)	2012	odistr	ar's Signa	turo	Ne s									
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 Year 2012 Physician/ P^{M} 6:30 Mary Bernice Backof Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Center Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Country) Maryland Hours (Month, Day, Year) 07/18/1931 Days 1 □ M 2 🖒 F Director 213-28-4277 81 Yrs Usual Residence of Deceden Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Wedical Examiner must be notified at permit. Pege 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural" ---- any injury or other traumatic event any injury or other traumatic event any injury or other traumatic event. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 ☐ No MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 21236 USA 4300 Cardwell Avenue, #319 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married If Yes, Give Year or Dates. 1 ☐ Yes 2 ☒ No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 12 Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ည Bernard Ritmiller Leanora Hahn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Alfred A. Backof / Husband 4300 Cardwell Avenue, #319, Baltimore, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🗆 Burial 2 ี Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 12/14/2012 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Ø disease or condition CA Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): sician end burial-transit Hospital or Attending Physician: The law requires that the death certificete be executed that initiated events Due to (or as a consequence of): resulting in death) Last After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 1 Yes 2 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: After this certifica etely filled in by the funeral director. 26. Place of Death (Check only one) æ 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 2 No 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 8c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending Natural 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Funer completely fi 29a. Certific Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Check only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the 9b. Signature nd title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Mandrin Hospice House Harwood Anne Arundel 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Days Months Hours Min. (Month, Day, Year) Director 214-66-0991 10M 2 D F Yrs 58 02/19/1954 Usual Residence of Decedent DC ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No MD Baltimore Gwynn Oak 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2017 Hillcrest Road 21207 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?, 1 ☐ Yes 2 ☐ No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes, Give 3 Widowed 4 XDivorced Specify. Year or Dates White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) pernit, Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Licensed Practical Nurse Health Care æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Albert Frank Bateman Helen Elizabeth Bateman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Linda A. Bateman / ex-wife 6041 Charles Street, Gwynn Oak, MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Cem. 12/19/2012 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1 2nd Ave, SW Glen Burnie, MD M01357 Singleton Funeral & Cremation Services, 23a. Part 1. Ener the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition nset and Deat Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence off ettending physician and for use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 2 No Yes 1 🗆 Yes within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Yes 2 1 MG Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospice 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Matural 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4
Homicide determined Medical 29a. Certifier 1 Q Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ertifying Nurse Practitioner: To the best of my knowledge, death irred at the time, date and plane, and due to the cause(s) and marker as stated l 🔿 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YIOR DEFENSE HWY, ANDAPOLIS, M

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deat Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death U andaliston 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Min. Hours Director 218-48-2144 1 M 2 X F 63 Yrs. May 3 1949 OK or than "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD BALTIMORE Randallstown 1 ☐ Yes 2X No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20 Cinnamon Circle Apt. 21133 USA 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. δ 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Maryland 21215-0036 withIn 72 hours after 1 ☐ Yes 2 No Specify: Completed 3 ₩ Widowed 4 Divorced Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) al Hyglene, (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Yrs actory Worker Embroidery Company Be fllad 17. Father's Name (First, Middle, Last) iga 1 and 2 should be filac nt of Health and Mental H t: if item 27 is marked ot 18. Mother's Name (First, Middle, Maiden Surname) NATHANIEL Woods Dorothy Massey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa Henson - Daughter 2217 Ashburton St. Baltimore, 21216 altimore, 20a. Method of Disposition parmit, Paga 1 al Departmant of H Important: If Itel any injury or oth 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State Garrison Forest Vet. 12/17/2012 4 Donation 5 Other (Specify) Owings Mills, MD 21. Sig athra of Funeral Service License Managerand Andrews of Wagility t 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that severed shock, or heart/gilure. List only one cause on such line. sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician Onset and Death se or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attanding Physician: The law requires that the death certificate be executed for use as the burlal-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year detached baen signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 this certificate performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: |은 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending To the Hospital or Attandir within 24 hours after death. To tha Funeral Diractor: Af completaly filled in by the fu Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signature and tit 29d. Date signed (Month) Day, Year) 30. Name and address of person who completed o of death (Item 23a) (Type, Print) rearacta State Registrar

Patient Known as Allen Block Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

	1 - For State of Maryland / Department of Health and Mental Hygiene 2012 40942 Certificate of Death															
		Registrar 1. Decedent's Name (First, Middle, La	st)			Gillicate		caur		2. Date of De	Reg. No),		3. Time of De	eath
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Examin		4a. Facility Name (if no			4.45	_	4b. City,			of Death		4c	. County of D	eath		
Funeral		Singu Hu 5. Social Security Num	OSPITUL ober 6. S		. Age (In yrs. Ia			Him 1 Year	ore If Under	24 Hrs.	8. Date of Bi	rth	N/A	Birthole	ace (State or F	oreign
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permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 ☐ Donation 5			M	OSES	MONTEF 22. Name and		_		5/2012 LEVIN		SALTIMO			
permi Depar Impo any ir	9 (4	Man									ROAD,				MD 2120	08
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State of Manyland / Department of Health and Mental Hydiene

		1	For State Registrar	State of Marylar		artment of F rtificate of L			Reg. No. 2012	2 40943
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Me Exan	dica nine		la. Facility Name (if not institution, give	street and number)	1	4b. City, Town, or	r Location of Deat		4c. County of Dea	
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21215-0036 within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f show, the Medical Examiner must be notified at		2	11. Marital Status 1 D Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.		Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	Specify:	to Rican, etc.)	14. Race - Am Black, Wh Specify:	lack
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Mar d 2 shou alth and 27 is m			19a. Informant's Name/Relationship (7)	aughter	19b. Maili 302 6	ing Address (Street 2 Pop la v	and Number or R	ural Route Number	Howere N	laryland
Baltimore, loemit. Page 1 and Department of Heal Important: If item 2 any injury or other		1	20a. Method of Disposition 1 Deurial 2 Cremation 3 4 Donation 5 Other (Specification)	Domoval from State	Place of Disponentery, cre	osition (Name of matory or other place Vw ClME	en 12	Date 122/12	20c. Location - City of Baltimor	or Town, State L, Maryland
Baltimo permit. Page Department o Important: If any injury or	ouce.	Ī	21. Signature of Funeral Style Licens		2	2. Name and Addre	de vick	Kerfu Ave. Bo	neral Hom	e P.A. 21229 Varyland
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Division tal or Attendings after death.	1	Certificate:	3 Suicide 6 Could not be determined	e 28e. Place of Injury - At h building, etc. (Speci	nome, farm, st	treet, factory, office		28f. Location (S City or Tov	Street and Number or I vn, State)	Rural Route Number,
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To th within To th	1		29b. Signature and title of certifier)	167	29c. Licens	se number 7 1 5 4 2	-	29d. Date signed (Mo	nth. Day. Year)
かく			30. Name and address of person who	completed cause of death (Ite	m 23a) (Type,	Print) Bon S	ecours t	tospitul	ED 2000 V	U Baltimore St
Regi	State stra		31. Date filed (Month, Day, Year) OEC 1 8 20	32 Registrar's Sign	ature	arke				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 40944 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 07, 2012 JUDY MAY CARVER 1:50P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Essex Baltimore Riverview Nursing Home 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Days Hours Min 214-74-7464 63 Director 1 M 2XXF 11/10/1949 Maryland Usual Residence of Deced 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director notified 1 ☐ Yes XX No 28a-f Baltimore Maryland Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò must be r Funeral 3616 East Joppa Road 21234 USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Black, White, etc. 1XXNever Married 2 Married 1 Yes 2XX No If Yes, Give Year or Dates. ō þ permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify: White "natural" Completed 3 Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Disabled None Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ပ John Wilson Carver Frances Elizabeth Welch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephanie Helfman PR 7215 York Road Baltimore, Maryland 21212 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date detro Crematory or other Metro Crematory 12/19/12 Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) ignature of Funeral 22. Name and Address of Faci Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death A THERO SCLEROFIC CARDIOVASULAR DISÉA Immediate Cause (Final Phy i ian/ disease or condition Medical resulting in death) **Examiner** TENSION sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine burial-transi Cause (Disease or injury that initiated events resulting in death) Last and physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Day signed by the at the detached for 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ETARDATION NITA 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an autopsy page 2 1 Yes 2 No funeral director. To Be 25. Was case referred to medical 26. Place of Death Check only one! Other: 1 \sum Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at injury 1 Natural 5 Pending work?
1 Yes 2 No 24 hours after death. Funeral Di ector A Accident Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. the only one 29b. Signature⊶nd title of certifie 29c. License number

State

COCKBURN, MARC ARET ESTHER STR

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The part of the disease or original part of the part 12 months of	212	within glene. er ther		Elementary/Secondary (0-12)	College (1-4 o	or 5+)			,	ry							n the
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Section Personal	aryl	hould bend Me					19b. Mailin	g Address	(Street a					or Town, St	ate, Zip C	ode)	
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Solo York Rd. Baltimore, MD 21212	3alti	epertm epertm nporta ny inju nce.			ensee	pac C1										THAL Y	Lana
PTYSIC COT Medical Examiner Page		© 0 = 0		23a, Part 1. Enter the disease or o	a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.												
Second Toward T		Physician/	8 -	shock, or heart failure. List on Immediate Cause (Final	ly one cause on each l	ine. TE T	_					respiratory at	1031,			Interval Be	etween
Due to (or as a consequence of):					a. Due to (or a	is a consequ	ence of):								+		
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Second Color Seco		ocuted and trensit	xami	Cause (Disease or injury that initiated events	. ATHE	JR05		OTIC	2	CAR	DIOV	/ASCUL	AR	2	\perp		
FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 1 Ves	0	skicien e		resulting in death) Last	Due to (or a		,										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RONALD JEFFREYS D.O. 7601 OSLER DRIVE TOWSON, MARYLAND 21204	928	tificete Ing phy e es the	Medi	IF FEMALE:													
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RONALD JEFFREYS D.O. 7601 OSLER DRIVE TOWSON, MARYLAND 21204	ox 6	eth ce ettend i for us	ician/	in the past 12 months?	1 🔲 Live Birt	h 2.∐Fetal	Ideath 3 🗔			,						-	Year
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RONALD JEFFREYS D.O. 7601 OSLER DRIVE TOWSON, MARYLAND 21204	sion	ttendli deeth. stor: Al y the fu	tifica	2 Accident Investiga 3 Suicide 6 Could no	ation				1 🗆 `		_						
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RONALD JEFFREYS D.O. 7601 OSLER DRIVE TOWSON, MARYLAND 21204		To the within To the compl	Σ		0 00		y knowledge,				e and pla	ce, and due to t					
RONALD JEFFREYS D.O. 7601 OSLER DRIVE TOWSON MARYLAND 21204		NW N		I Forth O				H	00:	523	65			12-	15-	12	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		of Mr.				death (Item			DA	ZIVE	To	U)SAI)	MA	1941	TUP	2/2	104
			e	31. Date filed (Month, Day, Year) DFC. 1 8 2012		trar's Signatu	tarke					,	<u>, , , , , , , , , , , , , , , , , , , </u>	2101	,,,,,		

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		1- For State Certificat Registrar	e of Death	Reg. N	No. 2012 4094
Physici I Exam	3117	1. Decedent's Name (First, Middle,Last)		Month Da December 15	
II EXUIII	11.01	Aida Miranda Carrasquillo 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deal		4c. County of Death
		University Hospital	Baltimore		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	ay) If Under 1 Year If Under 24Hr	rs. 8. Date of Birth (N	M/DD/YYYY) 9. Birthplace (State or
Director		584-63-2367 584-63-8367 1□ M 2区F 48	Months Days Hours Mi	n. 12/23/	1963 Foreign Country) Puerto 1
		Usual Residence of Decedent		12, 23,	
any		10a. State 10b. County 10c. City, Town or			10d, Inside City Limit
nd show	اج	Maryland Harford Abero	deen		1 XXYes 2 N
Maryland 28a-f show datonce.	Director	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Country?
ted within 72 hours after death with the Maryland ygique. other than "natural", or items 23a nr 28a-f sho other than "natural", or items 23a nr 28a-f sho the Medical Examiner must be notified at once.	Ē	743 Walker Street	21001		USA
with ns 23 be no	eral	11. Marital Status 12. Was Decedent Ever in U.S. 1	3. Was Decedent of Hispanic Origin? (§		14. Race - American Indian, Black,
or iter	Fune	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puert		White, etc.
after al", o	by F	3 Widowed 4 X Divorced If Yes, Give Year or Dates:	1 Yes 2 No specify: Puc		
ours		15. Decedent's Education (Specify only highest grade completed) 16a. De	cedent's Usual Occupation (Give kind of ring most of working life. DO NOT use re		b. Kind of Business/Industry
hin 72 h e. than "n edical E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		,	
vithir ene. er th Medi	Ē	12 5	chemist		private industry
ld be filed within 72 hours afte fental Hygiene. narked other than "natural", event, the Medical Examiner		17. Father's Name (First, Middle, Last)	18.Mothers Nam	ne (First, Middle, Maid	•
ould be fill Mental H marked ic event, i	Be	Modesto Miranda Villatine 19a. Informant's Name/Relationship (Type, Print) 19b. 1	Mailing Address (Street and Number or	L. Carras	-
	욘		-	Camp Hill	
Pages I and 2 shou ment of Health and I tant: If item 27 is n or nther traumatic			Oakwood Circle, Disposition (Name of cemetery,		Oc. Location - City or Town, State
of H of H If it			r or other place) Funeral Chapel 12	2/19/12 I	Forest Hill, MD
tment trant		4 Donation 5 Other Specify:	- 1		•
permit. Pages 1 ar Department of Hes Important: If ite injury or nther tr		21. Signature of Funeral Service Licensee	Aberdeen, Maryla	rring-Caro	go Funeral Home, P.A
	\vdash	23a. Part I. Enter the disease, or complications that caused the death. Do not e			shock, or heart Approximate Interva
ysician Vedicul		failure. List only one cause on each line.			Between Onset and Death
aminer		Immediate Cause (Final disease or condition resulting in death) a Complications of Multiple Injur Due to (or as a consequence of):	ies		
		Sequentially list conditions, b			
	je	if any, leading to immediate Due to (or as a consequence of):			
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rtifica ing pl as th	2	23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pregr	nancy	Month Day Year
eath certificate attending phys for use as the b	Sici	Pregnant at time of death 5	Other (Specify)		
he de	Physician/M	Part II. Other significant conditions contributing to death but not resulting in	a the underlying cause given in Part I	23e Did tobac	co use contribute to the cause of death?
requires that the been signed by t should be detache	þ	Fair is Other significant conditions Continuing to death but not resulting in	The anderlying eduse given in Fart.	i .	No 3 Probably 4 Unknown
quires an sig	ted		·	24a. Was an	24b. Were autopsy findings available
law requi has been 2 should	ple			autopsy performed	prior to completion of cause of
The la	Completed			1 Yes 2 ✓	
cian: The certificate ector, page	Be	25. Was case referred to medical examiner?	26.Place of Death (Check		
hysic this c	일	1 ✓ Yes 2 No Inpatient 2 ER/Outp		ing Home 5 Res	
liog Ph After t funeral		1 Notice (Month, Day, Year) 0620 h	ne of Injury 28c. Injury at Work?	28d. Describe how Driver auto aut	
e	atio	1 Natural 5 Pending Dec 11, 2012 0629 Pending 2 ✓ Accident Investigation	1 Yes 2 ✓ No		
ttend death tor: / the	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm	n, street, factory, office building, etc.	or Town, State	et and Number or Rural Route Number, City
or Atter after deat Director I in by th	je j	4 Homicide determined (Specify) Local Street		Darlington Road	and Wilkinson Road , Havre De Grace
spital or Atter nours after deat oeral Director filled in by th		29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death one) 2 ✓ Medical Examiner: On the basis of examination and/or inv			
ne Hospital or Atter n 24 hours after deat ne Fuoeral Director letely filled in by th					
		and manner stated.	29c. License number	29	d. Date signed (Month, Day, Year)
To the Hospital or Atter within 24 hours after deat To the Fuoeral Director completely filled in by th	Medical (and manner stated. 29b. Signature and title of certifier	OCME	- In	lecember 17 2012
To the Hospital or Atter within 24 hours after deat To the Fuoeral Director completely filled in by th		29b. Signature and title of certifier	O.C.M.E.	D	ecember 17, 2012
		29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a)			
· /	Medical	29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) Donna M, Vincenti, MD Assistant Medical Examiner	O.C.M.E. 900 W. Baltimore Street, Balti		
/	Medical	29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Repair's Signature			

DHMH 17 Rev 1/2001 OCME 2006

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State of Maryland / Department of Health and Mental Hygiene 2012 40947

Sharon Elaine Cour	1- For State	State of Maryla	•	tment of ificate of		d Mental H		2 U eg. No.	12 4094
Physician/ Modical Examiner	1. Decedent's Name (First, Sha	, Middle,Last) aron Elaine	e Court	ney			2. Date of Deal Month December	th	3 Time of Death 1155 hrs
)	4a. Facility Name (if not ins				b. City, Town, or	Location of Deat		4c. County of	
Funeral	7601 Park Drive 5. Social Security Number	6. Sex	7. Age (In yrs. las	t birthday)	Parkville If Under 1 Yea	r If Under 24Hr	s. 8. Date of Bir	Baltimore th(MM/DD/YYYY)	9. Birthplace (State or
Director	213-80-637	77 _{1 M 2 X F}	ī	53 _{Yrs.}	Months Days	Hours Mir	June	22,1959	Foreign Baltimore Country) MD
any	Usual Residence of Deced 10a. State 10b. Co		10c. City, T	own or Locati	on				10d. Inside City Limits
	MD E	Baltimore		Park	cville				1 Yes 2 X No
r death with the Maryland or items 23a or 28a-f show must be notified at once. Funeral Director	10e. Street and Number 7601 Par	k Drive	-		10f. Zip Code 212	34	1	Og. Citizen of What United:	·
death with th or items 23a on must be notifi uneral [11. Marital Status	12. Was Dec	cedent Ever in U.S.		s Decedent of Hises, specify Cuban	panic Origin? (S			American Indian, Black,
er death	1 Never Married 2 3 Widowed 4	Married Armed Fr 1 Yes Divorced If Yes, Give Yes	2 X No	1	Yes 2 X No		o ricali, etc.)	Specify:	White
iours aft	15. Decedent's Education	or Dates: n (Specify only highest grad	de completed) 1		t's Usual Occupat	ion (Give kind of		16b. Kind of Busin	
5-0036 ted within 72 hour tygiene, other than "natu the Medical Exan Completed	Elementary/Secondary ((0-12) College (1	1-4 or 5+)		Manag		,	Inv	entory
215-0036 be filed within 7/ intal Appendent than risked other than ent, the Medical Be Comple	17. Father's Name (First, M Joseph Sm						e (First, Middle, M Ly Rave	Maiden Surname)	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatie event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	19a. Informant's Name/Rel David Cou	lationship (Type, Print) rtney, Jr.	-Son					nber, City or Town, r, Maryl	State, Zip Code) and 21 0 1 5
Ore, Pees I and to of Healt to Healt in Witem trans	20a. Method of Disposition 1 X Burial 2 Crei	mation 3 Removal fr	om State Gari	endternerett			cember 2012		ity or Town, State Maryland
Baltimore, permit. Pages I a Department of He Important: If ite	4 Donation 5 Ott 21. Signature of Funeral S			Cemete 22 N Ey	ery ame and Address Zans Fu			& Cremat	ion Services 0 21234
Physician		or complications that	used the death. [88 Oo not enter th	300 Har ne mode of dying,	ford Rosuch as cardiac	d. Park or respiratory arr	est, shock, or hear	Approximate interval
/Medical Examiner	failure. List only one Immediate Cause (Final di or condition resulting in de	isease a Mixed D	rug Intox		on (Morph:	ine and	Fluoxeti	ine)	Between Onset and Death
<u>.</u>	Sequentially list conditions if any, leading to immediat		a consequence of):						
ed nsit	cause. Enter Underlying ((Disease or injury that initial	Cause c.	a consequence of):						
executed an and al - transit	events resulting in death)	d							
O, e be execu ysician an burial - tr	X UNPENDED		23a,27,28		er me,g9	35 1-9-1	3 sm	1 22d Data of di	Niver
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit edical Certification: To Be Completed by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnal past 12 months? 1 Yes 2 No 9 ♥	ant in the 1 Live b	nant at time of deat	₂ Fe	tal death 3 (ner (Specify)	Ectopic pregn	ancy	23d. Date of de Month	Day Year
P.O. Be es that the de gened by the edetached for by Phy	Part II. Other significant of			ulting in the u	nderlying cause g	jiven in Part I.			ite to the cause of death?
IS, P.(quires that en signed and be det	J. ————	·					1 Yes		Probably 4 Unknown
of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by funeral director, page 2 should be detach on: To Be Completed by P.							autop perfo 1 ✓ Yes	sy prid rm <u>ed</u> ? dea	or to completion of cause of ath? Yes 2 No
Vital ysician: ysician: director	25. Was case referred to mexaminer?	Hospital:	Inpatient 2 E	R/Outpatient		of Death (Check Other: Nursi		Residence 6	Other: Scene
n of \ding Phy. After the funeral funeral on: To	27. Manner of Death	28a. Date (Month	of Injury n, Day,Year)	28b. Time of I		ry at Work?	28d. Describe l	now injury occurred	
Division of standing its after death. 14 Director: After led in by the fune extification:	2 Accident	280 Place	2-12-12 1 ce of Injury - At hon	Ed 11:5	v am	res 2 X No			or Rural Route Number, City
Division ospital or Attend hours and after death meral Directors by filled in by the Certification	4 Homicide	Could not be determined (Specify)	Single F	amily	Ноте		or Town, S Parkvil	tate) /601 Pa 1e,MD.	ark Dr.
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		ying Physiclan: To the best al Examiner:On the basis	of examination and						
To with the con	29b. Signature and title of	and manner s certifier	stated		29c. Licens				(Month, Day, Year)
	Hunea Sou	ithell, m		220)	O.C.	M.E.		December 1	3, 2012
Ø	Pamela E. South		Medical Exam	niner 900		e Street, Balt	imore, MD 2	1223	
State Registrar	31. Date filed (Month, Day,	2012 Serve	egistrar's Signature	park					

COME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent Name (First, Middle, Last) 2. Date of Death Physician/ Month 3:30 KM 20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 805 N. Augusta If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 T Months Hours 1/1/2011 Bay, 1/91 6 VA 96 213-28-2686 **Director** Jsual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10b. County Director MD Baltimore 1x Yes 2 □ No 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21229 805 Augusta hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. ò 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Specify:Black 3XXWidowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Nurses Aid Health Industry injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Emma Pratt Robert White permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5313 Plymouth Rd., Baltimore, MD 21214 Boonie Coleman/daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 12/21/2012 King Memorial Park 22. Name and Address of Facility James A. Morton & Sons F. H., inc 21 Signature of Fureral Service Licensee 1701 Laurens St., Baltimore, MD 21217 ame 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to or as a consequence of Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) jo in the past 12 months? Month Day Pregnant at time of death 2 No detached g Unknown signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Dhadlu completed filled in by the funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performe 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title 29d. Date signed (Month, Day, Year) (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene 20 | 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ 12 8:32 PM arence Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical Center Baltimore 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Social Security Number **Funeral** Hours Director 218-24-9134 1 X M 2 | F 83 June 20,1929 Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County Director 1 ☐ Yes XX No MD Baltimore G1yndon 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral U.S.A. 21071 107 Railroad Ave. 12. Was Decedent Ever in U.S. Armed Forces?

XIV Yes 2 □ No
If Yes, Give Year or Dates. WW I Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married XX Married \$ Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: White 3 Widowed 4 Divorced Completed WW II 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Building Inspector Baltimore County 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ethel McQuay Clarence W. Caples, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Paga 1 and 2 sh Depertment of Health ar Important: If item 27 Is any injury or other trau 107 Railroad Ave. Glyndon, MD 21071 Leona M. Caples / Wife 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 12/20/12 Evergreen Memorial Gardens XIX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Finksburg, MD 21. Signature of uneral Service Licens 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Seps is disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: "he law raquires thet the daath cartificate ba exacuted within 24 hours after death.
To the Funerel Director: After this certificate has bean signed by the attanding physician end completaly filled in by the funaral director, "age 2 should be datached for use as the buriel-trensit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes မူ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: injury 1 Matural 5 \square Pending 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) NPI# 1316203128 12/16/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kaufmann Bultmore, MD Greene St 31. Date filed (Month, Day, Year)

DEC 1 8 2012 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 11, 2012 Louis Craig Castagnola 8:18 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Suburban Hospital Bethesda Montgomery Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Hours 223-44-6238 Director 1 X M 2 □ F 76 July 5, 1936 North Carolina or than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Rockville Maryland Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20850 1852 Greenplace Terrace United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Yes 2 No Armed Forces' Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Specify. 3 Widowed 4 Divorced Completed White Year or Dates 1956 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, <u>the Me</u> College (1-4 or 5+) Elementary/Secondary (0-12) District Manager Computers Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Louis Kametches Edna Chadwick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1852 Greenplace Terrace, Rockville, Maryland 20850 Jo Ann Castagnola/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State December 18, cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Forest Lawn Cemetery Norfolk, Virginia 2012 21. Signature of Funeral Service Licensee 22. Namme and Address of Facility
Robert A. Pumphrey Funeral Home, Rockville, Inc.
300 W. Montgomery Avenue, Rockville, Maryland 20850 William A. Try M01173 23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one groups that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Traumatic Brain Injury disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner m Fall Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director, After this cartificate has been executed to the control of the control attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Month Year 1 ☐ Yes 2 ☐ No 9 ☐ Unknown been signed by the a should be detached 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗆 Yes 2 💆 No 3 🗔 Probably 4 🗀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed 1 ☐ Yes 2 ☐ No 2 💹 N Division of Vital director 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☑ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year, 12/1/12 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 X Accident 5 Pending 1:00 PM 1 ☐ Yes 2 🔀 No Fell from roof Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1852 Greenplace Ter. determined To the Hospital or within 24 hours aff To the Funeral Dis completely filled in Home Rockville, Maryland Medical 1 Certifyind Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical I aminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Chec only Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and title of certific 29b. Signa 29d. Date signed (Month, Day, Year) D42181 December 13, 2012

Registrar

DHMH 17 Rev 06-2011

State

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astagnolas

6420 Rockledge Dr., Suite 2200, Bethesda, MD

20817

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar' Signatu

Enrique Daza Racines,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 1 Elaine Clark 201^{res} 07:27 AM Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Tate Hospice House Linthicum Heights Anne Arundel Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Hours 217-20-0732 Country) **Director** 1 □ M 2 🔀 F MD 88 May 25 1924 Usual Residence of Decedent show filed within 72 hours after death with the Maryland al Hygiene. Jother than "natural", or items 23a or 28a-f sho 10a. State 10b. County ms 23a or 28a-f sho must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Anne Arundel Pasadena 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21122 354 Dutchship Road USA ו "natural", or item ledical Examiner וו 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. δ 1 Never Married 2 X Married 1 ☐ Yes 2 🔯 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Household lith and Mental Hygie 27 is marked other r traumatic event, ti Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve Author Disney Jenny Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 354 Dutchship Road, Pasadena, MD 21122 Thomas C. Clark (spouse) Baltimore, 20a. Method of Disposition Date 11 20b. Place of Disposition (Name of cemetery, crematory or other pla 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. Baltimore, Maryland Ž012 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License . Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasádena, MD 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Theroschoonic disease or condition resulting in death) Coronary Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and defached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 5 Other (specify) Pregnant at time of death Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? After this certificate has been significate has been significated and a should in the same of the same 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ė 1 Yes 2 No Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate; 28b. Time of 28c. Injury at 28d. Describe how injury 1 Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2 To the I only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00063770 2010 30. Name and odress of person who completed cause of death (Item 23a) (Type, Print) 8601 211 Millersu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	or 2 be no		10e. Street and Number				10f. Zip Code				10g. Citizen	of What Cou	intry?	_
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က	er dea or ite niner	by Fu	11. Marital Status1 ☐ Never Married 2 ☐ Marrie	12. Was Decedent E Armed Forces? 1 \(\sum \) Yes 2\(\frac{\frac{1}{3}}{3}\) I			Vas Decedent of His Yes, specify Cubar					Race - Amer Black, White		
003	urs aft :ural", al Exal	ted k	3 🕅 Widowed 4 □ Divorced	If Yes, Give Year or Dates.		1	Yes 2 X No	Specify:			Spe	^{cify:} Whi	te	
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Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	17. Father's Name (First, Middle, La	,	atti	2		18. Mothe		(First, Middle,		_{ame)} rtona		
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Box 687	eath certifica attending p	ian/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 🗌 Fetal	death 3	Ectopic pregnancy	/				Date of deliv	*	
B	ne dear / the ar ched fo	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of de	eath 5∟	Other (specify)					Month	Day Year	
P.0.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	by Physician/M	Part II. Other significant condition	contributing to death bu	it not resu	Iting in the ur	nderlying cause give	en in Part I	l.	23e. Did to	bacco use c	ontribute to t	he cause of death?	
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Division of Vital Records,	e law re has by je 2 sh	Completed	pulmo	nary n	ype	Hu!	57017			24a. Was autop			psy findings available empletion of cause of	
Ĕ	tal or Attending Physician: The law is after death. al Director. After this certificate has been in by the funeral director, page 2 section.	Be Co	25. Was case referred to medical	1 -			26 Pla	ce of Deat	th (Check o	1 Yes		1 Yes	2 No	
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n of	ting Pl n. After th funeral	ate:	27. Manner of Death 1 Natural 5 Pending	28a. Date of injury (Month, Day,	Year)	28b. Time of injury	28c. Injury work?		- 1	8d. Describe h	ow injury occ	urred		
SIO	Attence r. death	Certificate:	2 Accident Investiga 3 Suicide 6 Could no 4 Homicide determin	ot be 28e. Place of Injur	y - At hon	ne, farm, stre		/es 2□	_	8f. Location (S	treet and Nui	mber or Rura	l Route Number,	
2	tal or irs afte al Dire		4 E Homicide determin	building, etc.	(Specify)					City or Tow	n, State)		,	h
	To the Hospital or A within 24 hours after To the Funeral Dire completed filled in b	Medical	(Check 2 \(\subseteq \text{ Medical Ex}	hysician: To the best of maminer: On the basis of ex	amination	and/or investi	gation, in my opinior	n, death oc	curred at t	he time, date a	nd place, and	due to the ca	use(s) and manner state	∍d.
	To the within To the compl	Σ	only one) 3 \square Certifying N 29b. Signature and title of certifier	lurse Practioner: To the b	est of my	knowledge, d	29c. License		and place		e cause(s) and 29d. Date sig			_
			> GLORS	yeur	Ar	~ 1	10.	034	4383	5	Dec	17,2	012	
			C C	no completed cause of de	ath (Item :	23a) (Type, Pi	rint)							
	Stat	e	31. Date filed (Month, Day, Year)	32. Zgistrar	's Signatu	re VII	~			···				_
	Registra		DEC 18	2012 Sum	v ,	9. As	ever							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 12/12 Day 2012 4:00 AM Zariya Ayanna Davis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Days Hours Min (Month, Day, Year) **Director** 841-09-1683 1 M 2 K F 9/22/2011 MD Usual Residence of Decede Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a, State or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X XNo Montgomery Village MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20880 USA 9426 Royal Bonnet Terrace 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 K Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2XXXNo Specify: Completed 3 Widowed 4 Divorced **Black** 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) N/A N/A Be ŧ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ is marked <u>Charles A.</u> Davis Alaina Raevon Cowan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20886 permit. Page 1 and 2 shu Department of Health an Important: If item 27 is any injury or other trau once. Alaina Cowan/Mother 9426 Royal Bonnet Terrace, Montgomery Village, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State All Souls Cemetery 12/19/12 Germantown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22Burrend Address Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause of each line. Annroximate Interval Between Onset and Death Immediate Cause (Final Physician/ ardia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner seizure Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed rebro attending physician and for use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day ed by the a eral Director; After this certificate has been signed by filled in by the funeral director, page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 2. No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ပ္ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No Accident
Suicide
Homicide Investigation 24 hours after deat Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical within 24 hou

To the Funer

completely fil 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tan Russell mD 31. Date filed (Month, Day, Year) (
DEC 1 8 201 32. Registrar's Signature State Registrar

0400

			Please ame	Type or Print in end items 19b State of Marylar	Black per fi d Dep	I ndeli Daftme	ble Inl 4 12- ent of F	k. Ensi 20–12 fealth a	ure A vt and M	II Copie 10e Iental Hy	s Are	e Legi	ble.	
		1	State Registrar				te of L				Reg. No	201	2	40954
	Physicia	n/	1. Decedent's Name (First, Middle, Las	ot)						2. Date of De	eath , Da	ıv	Year	3. Time of Death
	Medic	al	Vicki Lynn Debor 4a. Facility Name (If not institution, give				-		(D. 1)	Dec.	14	201		03:15 P ^M
	Examin	er	Gilchrist Hospic				ty, Town, or DWSON	Location o	t Death			altir		
	Funeral		5. Social Security Number 6. S		last birthday) If Unc	der 1 Year	If Under 2	4 Hrs. Min.	8. Date of Bi	rth		9. Birth	place (State or Foreign
	Director		-10 00 10 1	□ M 2 🛛 F 55	Yrs.	Month	S Days	Hours	WIII I.	Aug.7,		·	Coui Kent	ucky
	ahow	P	Usual Residence of Decedent 10a. State 10b. County	10c. C	ty, Town or L	ocation								10d. Inside City Limits
	Maryle	Director	MD	Ва	altimo	re								1 🙀 Yes 2 🗆 No
	h tha	aiDi	10e. Street and Number Grinnalds	•		10f. 2	Zip Code				10g. Ci	tizen of W	hat Cou	ntry?
	me 23	Funerai	ZUZ/ Grenotas AV		0 140	Was Da	2123		:-0 (C	-i6 . V N-		USA		
(0	or Ite	by Fu	11. Marital Status 1 ☒ Never Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ♣ No	.5.	If Yes, sp	ecify Cuba	ispanic Orig in, Mexican,	Puerto	cify Yes or No- Rican, etc.)			, White,	
ğ	ure!", LEver		3 Widowed 4 Divorced	If Yes, Give Year or Dates.	+175311	1 🗌 Yes	2 □ No	Specify:				Specify:	wn	ite
5-(72 hou	Completed	15. Decedent's E (Specify only highest gr		(Giv	e kind of v		ation during most	of worki	ng	16b. k	(ind of Bus	siness/Ir	ndustry
12	Athin a	S	Elementary/Secondary (0-12)	College (1-4 or 5+)	I		ıse retired) nanag€	er			he	alth	car	e
Ď.	filed v al Hyg d othe vent,		17. Father's Name (First, Middle, Last)		,				r's Name	e (First, Middle	_			
Уaп	Menta Merita erita etic e	잍	William Debord					Cathe	rine	e Asbur	У.			
Mar	S should hend if listre in treum		19a. Informant's Name/Relationship (T		1	iling Addre	ess (Street a	and Number	r or Rura	l Route Numb	er, City oi	r Town, Sta	ate, Zip	Code)
ē,	and heelt Haelt tem 2		William Debord / 20a. Method of Disposition		20 Place of Dis	27 G i	eno Lo lame of	Ave		Baltim Date	ore	ocation - 0	212 City or T	30 own, State
Ē	ega 1 ent of nt: If I		1 Burial 2 Cremation 3 4 Donation 5 Other (Special	Removal from State	cemetery, cr lantic	ematory`o	r other plac	ce) y I	_	16,2012			•	
Baltimore, Maryland 21215-0036	parmit. Pega 1 and 2 should be filed within 72 hours after death with the Marylend Department of Health and Mental Hyglane. Important: If them 27 is merked other then "neturel", or Items 23e or 28e-f show any injury or other treumetic event, the Medical Evantment must be notified at once.	21. Signature of Funeral Service Licensee										1 Hor	ne,	Inc.
	207 20		some.	nur Sp	ring	g Road	Arbu	tus,	MĎ	21227				
	110.5550	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca shock, or heart failure. List only one cause on each line.									rrest,			Approximate Interval Between Onset and Death
- 1	Medical disease or condition resulting in death) a. Due to (or as a consequence of):												-	
	Examiner		Sequentially list conditions,	h ————										
	sit d	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	quence of):									
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Box 68760	Attending Physicien: The law requires thet the death cartificate be in death. If death. Schor: After this certificate has been signed by the attending physicion by the funeral director, paga 2 should be dateched for use as the but the funeral director.	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn	ancv							001.0.1	-6 1-6	
30X	e atten d for u	iciai	in the past 12ymenths?	1 Live Birth 2 Fe 4 Pregnant at time of		☐ Ectopi		у			1	23d. Date Mon		Day Year
O .	t the d by the teche	Phys	9 Unknown	9 LJ Unknown							1			
, P.O.	as thei ligned be de	<u>م</u>	Part II. Other significant conditions of	ontributing to death but not re	sulting in the	underlyin	g cause giv	ven in Part I				10		he cause of death?
rds	requir bean s should	etec		-						24a. Was				opsy findings available
ecc.	3 00 01	Completed								auto perf	opsy ormed?	pr de	ior to co	empletion of cause of
<u>e</u>	en: Th rtificat xtor, p		25. Was case referred to medical				26. PI	ace of Deat	h (Check	1 L Yes only one)	2/Q\N	o <u>l</u> 1	∟ Yes	2 🗆 No
¥	hysica his ce al direc	욘	examiner? 1 ☐ Yes 2 XINo	Hospital: 1 ☐ Inpatient 2 ☐] ER/Outpati	ient 3 🗆	DOA Oth	er: 4 🗌 Nu	rsing Ho	me 5 ☐ Res	idence 6	Other	(Specif	nhospiq
jo c	ulng P	ate	27. Manner of Di⊷ith 1 Natural 5 □ Pending	28a. Date of injury (Month, Day, Year)	28b. Time injury		28c. Injur	?		28d. Describe	how injur	y occurred	t	•
Division of Vital Records,	Attender deat sector:	Certificate:	2 Accident Investigation 3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of Injury - At h		M treet, fact		Yes 2□	-	28f. Location	(Street an	d Number	or Rura	il Route Number,
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	To the Hospital or Attending Physicien: The la within 24 hours eftar death. To the Funerel Director: After this certificate he completely filled in by the funeral director, paga	Medical	29a. Certifier Certifying Phy (Check 2 Medical Exam	estigation,	in my opinio	on, death oc	curred at	the time, date	and place	e, and due	to the ca	ause(s) and manner stated.		
	To the within 2 To the comple	Σ	only one) 3 Certifying Nun 29b. Signature and title of certifier	se Practitioner: To the best of	rmy knowled;		9c. License	e number			29d Da	te signed	(Month	Day Year)
	11.		▶ Chanl				0	283	00	5	Dec	em	her	142012
•	AM		30. Name and address of person who	completed cause of death (Item		, Print)	N. (Cha	ملہ	Sr	50	MSU,	N/	142012
	Stat Registra		31. Date filed (Month, Day, Yan) 8 2	32. Sign		2.0							_	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 2 Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 12:25 PM Simone Davis 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1541 Becklow Avenue Baltimore 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Country) Belgium Days Hours Min. (Month, Day, Year) 06/23/1923 Director 1 □ M 2 🖎 F 213-28-2418 89 Usual Residence of Deceder or 28a-f show 10a. State 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 X No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21220 **USA** 1541 Becklow Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes 2 🔯 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify. Give Specify. 3 Widowed 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Did Not Work N/A Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F permit. Page 1 and 2 should be filk Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenn Davis / Son 1541 Becklow Avenue, Baltimore, MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/19/2012 Chesapeake Crematory Beltsville, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 Dorota Marshatt 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner MONTH Sequentially list on differs if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) nding physician and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No Month g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 Yes 2 No Yes within 24 hours after death.

To the Funeral Director: After this certifice completely filled in by the funeral director, I 25. Was case referred medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. May er of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier ifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Me i Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Ce_ufyin, Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one) 29b. Signature 29d. Date signed (Month, Day, Year) 30. Name an ause of death (Item 23a) (Type, Prin State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December ^D15. 1:30 P M 2012 Anita May Edwards Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Mt. Airy Kline House If Under 1 Year If Under 24 Hrs.

Manthe Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Director 220-58-5240 1 🗆 M 2 🔀 F Yrs. May 27, 1924 Canada 88 Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23e or 28a-f show ury or other treumetic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? United States 2502 Catoctin Court #3A 21702 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces ò 1 Never Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Environmental 12 Administrative Assistant Protection Agency Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Nancy Rose Melnyk Jaroslaw Ruryk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6871 Whistling Swan Way New Market, MD 21774 Daniel Edwards / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If its any Injury or of 90.00 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Flinal Journey Crematory 12/18/2012 Woodbine, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 -Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatic Breast Cancer Medical resulting in death) Due to (or as a consequence of) [∕]Examiner Breast Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence of signed by the attending physician and d be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? ş Hypertension, Hyperlipidemia, Completed Osteoarthritis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown After this certificate has been significate has been significated as Abound 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \boxtimes Other (Specify) HOSPICE 1 ☐ Yes 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27 Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at work? 1 🗆 Yes 2 🗆 No 1 X Natural 5 \square Pending death. To the Hospital or Attendi within 24 hours after death.
To the Funeral Director: A completely filled in by the fi 2 Accident
3 Suicide Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 D Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practitionar: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year)

- lon

State Registrar 1100 Baughmans Lane Frederick, MD 21702

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Susan Brinkley

31. Date filed (Month, Day, Year)

OEC 18

D0043389

December 17, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			Registrar	aryland / De	partment of Hea ertificate of Dea	alth and M ath	Re	g. No.	2 40957				
	Physicia Medic		1. Decedent's Name <i>(First, Middle, Last)</i> Alton Wesley Fisher				2. Date of Death Month December		3. Time of Death				
	Examin		4a. Facility Name (if not institution, give street and number) Gloria Friend's Assisted Liv	ving	4b. City, Town, or Loc	cation of Death		4c. County of					
	Funeral Director			(In yrs. last birthday	Months Days H	Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	9	Birthplace (State or Foreign Country)				
ŭ.		L	Usual Residence of Decedent 10a. State 10b. County	115.			Feb.28,1	922	Texas				
	Marylan 18a-f sh rtified a	recto	Maryland Baltimore	10c. City, Town or Midd	lle River				10d. Inside City Limits 1 ☐ Yes 2 🔼 No				
	with the I s 23a or 2 lust be no	Funeral Director	10e. Street and Number 9709 Matzon Rd.		10f. Zip Code 21220		10	g. Citizen of What	at Country?				
900	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Xwidowed 4 Divorced 12. Was Decedent Exampled Forces? 1 Xeys 2 New 1 Year or Dates. Will	No	3. Was Decedent of Hispar If Yes, specify Cuban, M 1 ☐ Yes 2 🔀 No S	/lexican, Puerto F	cify Yes or No- Rican, etc.)		American Indian, White, etc. White				
Baltimore, Maryland 21215-0036	ithin 72 hou ene. r than "natu the Medica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5-	(Giv	cedent's Usual Occupation ve kind of work done during DO NOT use retired) Driver		ng 1	6b. Kind of Busin	ness/Industry Transit				
land 2	d be filed w Mental Hygi Irked othe Itic event,	To Be	17. Father's Name (First, Middle, Last) John Michael Fisher		18.		(First, Middle, Ma h Mattie		ld				
, Mary	- L L =	Î	19a. Informant's Name/Relationship (Type, Print) William Linton (Stepson)	19b. Ma 97 0	ailing Address (Street and I 5 Matzon Rd.	Number or Rural • Baltin	Route Number, C	ity or Town, Stateryland 2	e, <i>Zip Code)</i> 1220				
timore	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 once.		20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place)									
Ball	permit Depart Impor any in)	21. Signature of Fig. and Service Economics	20.	22. Name and Address of Bruzdzinski 1407 Old Eas	Funeral stern Av	Home P.	A. sex, Mar	yland 21221				
48.	Physician/	9 30	23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Arteric	the death. Do not e		uch as cardiac or	respiratory arrest		Approximate Interval Between Onset and Death				
	Medical Examiner		resulting in death) Due to (or as a	consequence of):	tus								
20	uted Id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a Hyperte										
0	certificate be executed nding physician and use as the burial-transit	edical Ex	resulting in death) Last Due to (or as a	consequence of):									
68760	irtificati ling ph	/Med	IF FEMALE:					1					
Вох	death	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	Fetal death 3	B			23d. Date o	,				
	uires that the n signed by th uld be detach	ρ	Part II. Other significant conditions contributing to death bu	t not resulting in the	e underlying cause given ir	n Part I.			te to the cause of death? ☐ Probably 4 X Unknown				
Records,	has has	Completed					24a. Was an autopsy performe	prio dea	e autopsy findings available ir to completion of cause of th?				
ıta	sician: The certificate irector, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:		Othor	of Death (Check	only one)	Aggigte	d Livina				
o to	ng Phys fter this ineral d	ite: To	27. Manner of Death 1 ☐ Inpatier 28a. Date of injury (Month, Day,		of 28c. Injury at		ne 5 Residence 8d. Describe how	ce 6 K Other (S	Specify)				
Division of Vital	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certificate:	2 Accident Investigation			2 🗆 No 2	8f. Location (Stree		r Rural Route Number,				
٥	lospital of thours at numeral D	Medical C	29a. Certifier 1 Certifying Physician: To the best of m (Check 2 ☐ Medical Examiner: On the basis of exe	ny knowledge, deatl	h occurred at the time, dat	ite and place, and	d due to the cause	e(s) and manner	as stated.				
	Fo the H within 24 Fo the F complete	Me	only one) 3 Certifying Nurse Practitioner: To the	best of my knowledg	ge, death occurred at the tin 29c. License num	me, date and place	e, and due to the d	ause(s) and man	ner as stated. fonth, Day, Year)				
	Wan		· Fanher		Dis Fastern B	8326		12/11	+112				
	Hx 2		30. Name and address of person who completed cause of dea	ith (Item 23a) (Type	Eastern B	Ivel., B	altimo	re, M	D. 21221				
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar	's Signature	,								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Ruble Fansher December 9:58 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Howard County Columbia Howard Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth Birthplace (State or Foreign Country) Days Hours Min. Months (Month, Day, Year) 237-78-4320 Director 1 □ M 2 🏋 F 66 Yrs. 27, Texas Apr. 1946 Usual Residence of Decede 27 is marked other than "natural", or items 23a or 28e-f show traumatic event, it we Medical Examinar must be nutified at nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland rartment of Health end Mental Hygiene.

ortant: If item 27 is marked other than "natural", or items 23a or 28e-f sho injury or other traumatic event, the Mechael Examinar must be nuffiled at 10a, State 10b. Count 10c. City, Town or Location Director 10d. Inside City Limits Maryland Howard 1 Yes 2 X No Elkridge 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 6391 Rowanberry Drive, #115 21075 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 X Widowed 4 Divorced Specify: Completed White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Businesses Business Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Charles Ruble Virginia Lamb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Diaz / Daughter 7658 Blueberry Hill Lane, Ellicott City, MD 21043 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of H Important: If ite eny injury or ot once. 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Metro Crematory Inc. 12/18/2012 Baltimore, Maryland 21. Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland Inc 299 Frederick Road, Baltimore, Maryland 21228 Part 1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Onset and Death END STAGE KIDNEY disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ONGESTIVE Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury ettending physician and for use as the burial-transit the Hospital or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Vear Pregnant at time of death ed by the e g 🗌 Unknown .24 hours after death. e Funeral Director: After this certificate has been signed by to eletely filled in by the funeral director, page 2 should be detacl Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖔 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗆 No 1 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 🐼 No ျှ 4 ☐ Nursing Home 5 ☐ Residence 6 M Other (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🖺 Natural 5 Pending 1 🗌 Yes 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier 1 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and fittle of certiff 29c. License number 72139 MD 30. Name and andress of person who completed cause of death (Item 23a) (Type, Print) ABBAS SYED OLUMBIA 6336

State

Registrar

31. Date filed (Month, Day, Year)

8 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ George Francis Feeley, Sr. 6:07 P. M December 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Stella Maris Hospice Timonium 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Days Hours Min 218 22 4495 Director 1 ₹ M 2 □ F 84 Yrs 01/14/1928 Maryland Usual Residence of Decedent If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1X Yes 2 No N/A Maryland Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21225 U.S.A. 4111 Doris Avenue 12. Was Decedent Ever in U.S. Armed Forces?

1 ▲ Yes 2 □ No If Yes, Give Year or Dates. WW II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examina þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Baltimore City Elementary/Secondary (0-12) College (1-4 or 5+) Pump Operator Fire Department Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Patrick Feeley Margaret Brady 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DECEMBER 11, 4111 Doris Avenue Baltimore, Maryland 21225 Dolores Feeley / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Glen Haven Mem. Park 12/15/2012 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. 1. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ disease or condition resulting in death) TONGUE CANCER Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burlal-transit Cause (Disease or injury The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) ettending physician I for use as the burla Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant GEORGE FEELEY 3

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Dav 5 Other (specify) been signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an this certificate has ral director, page 2 performed? Division of Vital Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \square Nursing Home 5 \square Residence 6 \blacksquare Other (Specify) HOSPICE 1 ☐ Yes 2 X No <u>မ</u> 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending X Natural 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🖫 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 TRACIE L. MORGAN, 31. Date filed (Month, Day, Year) 62. Registrar's Signature State 8 Registrar

Physicia Medic		State Registrar 1. Decedent's Nam August				Cer	artment of F tificate of E	Death	:		leg. No.		3. Time of Death
Examir				give street and num Hospice	mber)		4b. City, Town, or		Death		4c. Count		th
Funeral Director		5. Social Security N 214-01-7 Usual Residence	umber 803	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs. 93	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24	Min.	B. Date of Birth (Month, Day, arch 1(Year)	Co	thplace (State or Foreign nuntry) Maryland
Aaryland Ba-f show tifled at	rector	10a. State	10b. County Balti	nore	10c. Ci	ty, Town or Lo		1 1					10d. Inside City Limits 1 ☐ Yes 2 ☒ N
with the N s 23a or 2 ust be no	Funeral Director	10e. Street and Nur 719 Maid	mber	ice Lane	HR343		10f. Zip Code 21228				10g. Citizen of USA	What Co	ountry?
should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	ed by Fun	11. Marital Status 1 □ Never Marr 3 ☒ Widowed		ried Armed F	2 🗌 No ve	'	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☒ No	n, Mexican, F	n? (Speci Puerto Ri	fy Yes or No- can, etc.)		ack, Whit	erican Indian, ie, etc. nite
rithin 72 hou iene. r than "natu the Medical	Completed	(Spe Elementary/Secr	ecify only highe	nt's Education est grade completed College (1) 1-4 or 5+)	(Give	dent's Usual Occup kind of work done o O NOT use retired) Shoreman	ation during most o	f working	ŀ	16b. Kind of B		/Industry
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	l		M. Fr	_{hip (Type, Print)} ederick-D		8900							p Code) City, MD 21
permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other once.		20a. Method of Dis 1 🖾 Burial 2 4 🗋 Donation	☐ Cremation	3 ☐ Removal from	n State	cemetery, cren John	osition (Name of matory or other place s Cemete	rv 12	Da 2/18/	2012	20c. Location	tt C	ity, MD
Depart Depart Impor any in		21. Signature of Fu	ineral Servide I	tudin-	_ mo	22	2. Name and Addre Funeral H 1630 Edmo	ss of Facility lome of ndson	Ster Cat Aver	cling A consvil nue: Ca	shton S le, Ind tonsvil	Schwalle,	ab Witzke MD 21228
hysician/ Medical Examiner		23a. Part 1. Enter shock, or hea Immediate Cause disease or condition resulting in death)	ırt failure. List o (Final	a. Due to	caused the dear ach line.	sis	er the mode of dyin	g, such as ca	ardiac or i	respiratory arre	est,		Approximate Interval Between Onset and Death
are be executed hysician and the burial-transit	dical Examiner	Sequentially list or if any, leading to in cause. Enter Unde Cause (Uisease or that initiated event resulting in death)	injuly S	c	(or as a conseq	W)= '							
death. tor. After this certificate has been signed by the attending physicates, the funeral director, page 2 should be detached for use as the I		IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	1 🗌 Live	gnant at time of	al death 3	Ectopic pregnand Other (specify)	ey .				ate of de	elivery Day Year
quires inat in en signed by ould be deta	ted by Pt	Part II. Other signi	ficant condition	ons contributing to	death but not re	sulting in the u	underlying cause giv	ven in Part I.					o the cause of death? Probably 4 Unknow
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tending rnysicians death. tor: After this certific the funeral director.	To Be	25. Was case referr examiner? 1 ☐ Yes 2 [Hospital:	Inpatient 2	ER/Outpatier	Oth	er: 4 D Nurs	_		ence 6 K Ot	her (Spec	city) HOSPICE
ter th	Certificate: 1	27. Manner of Deat 1 X Natural 2 Accident 3 Suicide 4 Homicide	h 5 Pendii Investi 6 Could detern	gation not be hined 28e. Place	e of injury nth, Day, Year)	28b. Time of injury	28c. Injun work	y at	28 lo	d. Describe ho	ow injury occur	rred	ural Route Number,
or Attendal liter death. lirector: Al in by the fu		29a. Certifier 1		Physician: To the Examiner: On the ba	sis of examination	on and/or inves	tigation, in my opinio	on, death occu	urred at th	ne time, date an	d place, and d	ue to the	cause(s) and manner sta
ne nospiral or Auentain 24 hours after death. P Funeral Director: All pletely filled in by the fu	Medical			Nurse Practitione	r. To the best of	my knowleage	, death occurred at t	ne lime, date					
to the nospital of Attention within 24 hours after death. To the Funeral Director: Al completely filled in by the fu	Medical		Certifying	Nurse Practitione	rr: To the best of)	29c. License		76	2	29d. Date sign	-	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40961 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day BACH AR Medical) PCOMA) P 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Months Director 217-16-6564 94 1 M 2 X F Yrs Oct. 8, 1918 Maryland 10a. State 10b. County 10c. City, Town or Location ould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other then "natural", or items 23a or 28a-f sho r then "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21204 USA 615 Chestnut Ave, Rm 415 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. Black, White, etc. 2 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed 3 X Widowed 4 ☐ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Insurance Underwriter New Amsterdam Casualty other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o မ Bornemann Charles **Blume** Augusta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19958 David H. Fischbach- SON 320 Mulberry St., Lewes, DE Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 12/15/2012 Atlantic Crematory Glen Burnie, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sterling Funeral Home of Catonsville . Signature of Funeral Service Licenses Ashton Schwab Witzke e, Inc. nsville, MD 21228 Mo123 Catonsvi 1630 Edmondson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician OBSTRUCTIVE PULMONARY DI +RONIC disease or condition PARC Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of). If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events ng physician and as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Box 68760 IF FEMALE: esn 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No ō Day within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached f 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 TYes 24b. Were autopsy findings available 24a. Was an autopsy perform prior to completion of cause of 2 No 1 Yes 2 1 No 25. Was case referred to medica Certificate; To Be 26. Place of Death_(Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Matural 5 Pending injury 1 Yes 2 🗌 No 2 Accident Investigation 3 🔲 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nerse Practitioner: It the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ICHAL 31. Date filed (Month, Day) State 8 Registrar

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راد سدم	Medic √⊾ Examin		Earl Crama 4a. Facility Name (if not institution, give	Flowers ve street and number)			4b. City, Town, o	r Location c		ecembe		1, 201	_	9:20 P M	\dashv
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Ī	Funeral		Social Security Number 6. 9	Sex 7. As	ge (In yrs. last bii	irthday)	If Under 1 Year Months Days			Date of Birt	th	9. [ace (State or Foreign	7
	Director >		417-14-2599 Usual Residence of Decedent	¹ X M ² □ F 9	91	Yrs.				ıg. 16			lab		
	land show	to	10a. State 10b. County		10c. City, Tow	wn or Loc	cation						10	ld. Inside City Limits	
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	ith the	ral	10e. Street and Number				10f. Zip Code 20817	7			-	tizen of What		•	
	ems (Funeral	9704 Montauk Ave	12. Was Decedent		13. V	Was Decedent of H	fispanic Orig	nin? (Specify	Yes or No-		ted St.	_		+
ထ္	or it	þ	1 ☐ Never Married 2 🔀 Married	Armed Forces? 1 ☑ Yes 2 □	?	"	If Yes, specify Cuba	an, Mexican,	, Puerto Rica	n, etc.)		Black, W	hite, et	c.	
8	ours el		3 Widowed 4 Divorced	If Yes, Give Year or Dates.]			1 ☐ Yes 2 ☒ No					Specify: W			
75	. 72 hc an "ns Medis	Completed	15. Decedent's (Specify only highest g	grade completed)		(Give F	dent's Usual Occup kind of work done (O NOT use retired)	during most	t of working		16b. Ki	ind of Busines	ss/Indu	ıstry	
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nd	e filed stal Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)						er's Name <i>(Fir</i>			Surname)			1
7	d Mer d Mer mark metic		Robert Crama Flo		10.				ie Lee						
Ma	12 shoulth and 27 is r trau		19a. Informant's Name/Relationship (Miriam Louise F.)b. Mailin)704	ng Address (Street a Montauk	and Number Avenu	er or Rural Roi e, Bet	ute Number hesda	; City or . , Ma	Town, State, aryland	Zip Co 1 2 ()817	1
ore,	1 and of Hea fitem	20a. Method of Disposition 20b. Place of Disposition (Name of Ular).													1
Ë	Page ment tant: ii	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1 Burial 2 Cremation 3 Removal from State Arlington National Cemetery March 6, 20											, V	/irginia	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumetic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licer	/Beth	hesda-Ch	nevy	Chase, Inc.	1							
	45-45	H	23a. Part 1. Enter the disease, or con		101662	<u> 175</u>	557 Wisco	nsin A	<u>Avenue</u>	, Bet	<u>hesd</u>	a, Mar	yla	and 20814	4
- P	Physician/		shock, or heart failure. List only Immediate Cause (Final	one cause on each lin	ne.			lg, such as c	Cardiac or res	pratory a	BS1,		1	Approximate Interval Between Onset and Death	
	Medical		disease or condition resulting in death)	a	tate Car a consequence								+-		\dashv
	Examiner												L		
	ed nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or as	a consequence	; of):									
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	te be a hysicia the bui	dical		d									\perp		
687	The law requires that the death certificate be ate has been signed by the ettending physici page 2 should be detached for use as the bu	_	IF FEMALE:	23c. If yes, outcome	of pregnancy										1
Box 68760	etter d for u	ician	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐ Live Birth 4 ☐ Pregnant a	2 Fetal deat at time of death		Ectopic pregnance Other (specify)	эу			1	23d. Date of o Month		y Day Year	
о В	the or	Shys	9 Unknown	9 🗌 Unknown											1
<u>a</u> .	igned be de	הַ	Part II. Other significant conditions of	contributing to death t	out not resulting	in the u	nderlying cause giv	ven in Part I.						cause of death?	
Spu	equire spen s should	eted							_					ably 4 Unknown	
eco	sician: The law a certificate has b lirector. page 2 s	Completed								24a. Was a autop perfor		24b. Were a prior to death'	o com	sy findings available pletion of cause of	
E I	an: Int		25. Was case referred to medical				26. PI	lace of Deat	h (Check only	1 🗌 Yes				□ No	+
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יס ר נ			27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of inju (Month, Da		Time of injury	work	y at	28d.	Describe ho					7
Sior	Attend r death ctor: A	Certificate:	2 Accident Investigation 3 Suicide 6 Could not to	be 290 Place of Init	iury - At home, f	farm, stre	M 1 🗆	Yes 2 □		Location (St	troot and	4 Number or I	Pural B	loute Number.	4
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	the Hospital or hin 24 hours afte the Funerel Dire mpletely filled in	ledical	I (Check 2 ∟ Medical Exam	ysician: To the best of niner: On the basis of e	examination and/	or investi	tigation, in my opinio	on, death occ	curred at the t	ime, date an	nd place	and due to th	e caus	e(s) and manner stated	
4	To the Hosp within 24 ho To the Fune completely f	2	only one) 3 Certifying Nur 29b. Signature and title of certifier	rse Practitioner: To th	ie best of my kno	owledge,	death occurred at t	the time, date	e and place, a	nd due to th	ne cause((s) and manner	r as sta	ated.	4
	- 3 F ō		DA SANA	mil 193	, CR	NP	R143			-		e signed (Mor			
	han	<u> </u>	30. Name and address of person who	completed cause of c		/ /					1 4	- 10	1 -		1
	2/4		Debrah Miller CRN				11 Road,	Rocky	ville,	Mary	1and	20855			_
	State Registra	e	31. Date filed (Month, Day Year) DEC 1 8 2012	32. Registra	ar's lignature	arth									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 000 AM Physician/ Ruth December 2012 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner NorthWest Randallstow Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday Funeral (Month, Day, Year) Days Hours Director 216-28-7099 1 🗌 M 2 🗓 F 03/23/1933 MD 79 item 27 is marked other than "natural", or items 23a or 28e-f show other traumatic event, the <u>Medical Examiner must be notified at</u> 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 ☐ Yeş 2 X No BALTIMORE PIKESVILLE 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 130 SLADE AVENUE, #309 21208 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status was Decedent Ever Armed Forces?
1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Completed 3 X Widowed 4 Divorced WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) 12 College (1-4 or 5+) MANICURIST BEAUTY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked of ည should be LEVITT DORIS LANDSMAN permit. Page 1 and 2 should Department of Heath and Me. Important: If item 27 is marke any injury or other tro-19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RONALD FADER / SON 1618 NATURO ROAD, TOWSON, MD 21286 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemeter, crematory of other place) ARLINGTON CEMETERY CHIZUK AMUNO 12/17/2012 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Usease or Injury Examiner Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed? 1 Yes 2 No 1 Yes 2 N 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျ 1 🗌 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗀 No 2 Accident
3 Suicide
4 Homicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) D65843 DECEMBER, 15, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) se or death (Item 23a) (Type, Print) 5401 old Court Road, Randallstown, HD 21133 Abdallah

Registrar
DHMH 17 Rev 06-2011

State

32. Registran's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 3. Time of Death A 2. Date of Death Physician/ RANT ENSE Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death LOSPITA 20126 SACT Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🔀 219-20-7994 Maryland 86 **Director** Usual Residence of Deceden 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD. 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21217 1832 Druid Hill Avenue USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 X Never Married 2 ☐ Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. 12th grade College (1-4 or 5+) Private Homes Domestic Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ald be file Mental ပ္ Howard Abraham Beckett Geneva Simpkins should and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Karen Grant/daughter Keyworth Ave. Baltimore, Maryland 21215 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 12/20/12 Woodlawn, Maryland 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licensee 5240 Reisterstown Rd.Baltimore, MD.21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset no D ath Immediate Cause (Final ONGESTIVE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed -transit and Due to (or as a consequence of): resulting in death) Last physician a /Medical Division of Vital Records, P.O. Box 68760 attending p IF FFMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Dav Year Pregnant at time of death 2 1 No the 9 Unknown Unknown þ s been signed b should be deta Part II. **Other significant conditions** contributin<u>a t</u>o death but not resulting in the underlyin<u>g ca</u>use given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DISCUTTE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 s performed 2 🗌 No Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗆 **K**o Hospital Other: မ 1 \square Yes 1 Impatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manne of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: ieral Director: After filled in by the funer (Month, Day, Year) 5 Pending atural 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral D

completed filled is Medical 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated of title of certifier 29b. Signatur ZOIZ 30. Name and address of bersop who completed cause of death (Item 23a) (Type, Print) 21201 345 305 EPPH

DHMH 17 Rev 7/2009

State Registrar

ASTA

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		for State Registrar	State of Maryla	and / Depa <i>Cer</i>	artment of F tificate of L	Health and I Death	Mental Hyg	iene _{leg. No.} 2012	40965	
Physicia		1. Decedent's Name (First, Middle, Last)		GRAY			2. Date of Deat Decembe	:h	3. Time of Death 2:15 P M	
Medi Examii		4a. Facility Name (if not institution, give street		UIVAT	4b. City, Town, or Chevy	r Location of Death	-	4c. County of Dear	th	
Funeral Director		Brighton Gardens 5. Social Security Number 6. Sex		. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. Bir	thplace (State or Foreign untry)	
	١.	131-14-3618 1 □ M 2 □XF 88 Usual Residence of Decedent 10a, State 10b, County 10c, City, T			Yrs. Se			Sept. 27, 1924 New York		
Marylar 28a-f sl	irecto	Maryland Montgomer		Chevy	Chase				1 🗆 Yes 2 🖺 No	
s 23a or	Funeral Director	10e. Street and Number 5555 Friendship Blv	d., #231		10f. Zip Gode	20815	1	10g. Citizen of What Co United S	*	
ore, INTALYIGHTU ZIZIO-0000 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 12. 1 Never Married 2 Married 3 Nidowed 4 Divorced	Was Decedent Ever in I Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.	ŀ	Was Decedent of H f Yes, specify Cuba ☐ Yes 2 🛣 No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.	
n 72 hou e. an "natu Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		(Give I	16a. Decedent's Usual Occupation (Give kind of work done during most of worki life. DO NOT use retired)			16b. Kind of Business.		
ld All	Be Co	17. Father's Name (First, Middle, Last)	4	Write	er/Editor		ne (First, Middle, N	Consumer Maiden Surname)	Affairs	
ryiallo	2	Benjamin Learner	T			yn Bimbe				
r, INICA nd 2 sho lealth and m 27 is i		Harold Gray, Son		4310	- 37th S	St., NW,	Washingt		800	
Page nent c		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Rer 4 □ Donation 5 □ Other (Specify)	C4-4-	Place of Dispo cemetery, cren rden of	natory or other place	nce Memo		20c. Location - City or k Clarks	town, State burg, MD	
permit. Departit Importa any inju		21. Signature of juneral Section Line nsee	5 MOLOT	78/ 1	Name and Addre Orchinsky	s Hebrew	Funeral	Home	20012	
Physician/		23a. Part 1. Easer the disease, or compilcate shock, or heart failure. List only one call immediate Cause (Final disease or condition		eath. Do not ente					Approximate Interval Between Onset and Death	
Medical Examiner	ı	resulting in death) Due to (or as a consequence of):								
ited d ansit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	equence of):	uence of):						
cate be executed physician and sthe burial-transit	dical Ex	that initiated events c resulting in death) Last	equence of):							
ortificate ling physics as the		IF FEMALE:								
the death ce by the attence ached for us	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy Month Mon						23d. Date of de Month	livery Day Year	
LIS, T.S. Iuires that in signed uld be de	eted by	Part II. Other significant continuous contributing to death out not resulting in the underlying cause given in Part II.								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transic.	Comp						24a. Was ar autops perform 1 \square Yes	sy prior to med? death?	topsy findings available completion of cause of	
hysician his certif	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hoss	1 Inpatient 2		nt 3 DOA Oth	ace of Death <i>(Chec</i> er: 4 Nursing H		ence 6 💢 Other (Spec	Assisted Living	
anding P eath. Ir. After the funera	Certificate:	1 Å Natural 5 ☐ Pending 2 ☐ AccidentInvestigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	work		28d. Describe ho	w injury occurred	Living	
al or Atte s after de l Directo		3	28e. Place of Injury - At building, etc. (Spec	ce of Injury - At home, farm, street, factory, office 28f. Location (Street) City or Town, 3				eet and Number or Rural Route Number, State)		
e Hospita 124 hours e Funera	Medical	29a. Certifier (Check only one) 1								
To the within To the comp	2	29b. Signature and little of certifier D 32033 29d. Date signed (Month, Day, Ye) December 18, 2							h, Day, Year)	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peter G. Hamm, M.D., 5530 Wisconsin Ave., #1150, Chevy Chase, MD 20815								
Sta Registr		31. Date filed (Month, Day, Year) SEC 18 2012	32 Registrar's Sign	A. Aa	wed					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40966 State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Year Winsome May Gaba DECEMBER 12:12 AM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE WASHINGTON MEDICAL GLEN BURNIE HRUNDEL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Birthplace (State or Foreign Country) **Funeral** 537-56-5693 64 **Director** 1 □ M 2 🔀 F Montego Bay, Jamaica Dec.01,1948 Usual Residence of Decedent or 28a-f show e notified at 10d. Inside City Limits 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 🗆 Yes 2 🔀 No Maryland Anne Arundel Co. Glen Burnie r items 23a or iner must be n 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21061 United States 1235 Kimberly Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status "natural", or iter Armed Forces?
1 Yes 2 No Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Jamaican If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) **04** Nursing Registered Nurse Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) 2 Conspearl Chisolm Unknown Chisolm 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr.Jean-Francois N'Dinga Gaba, Sr. Glen Burnie, Maryland 21061 1235 Kimberly Lane 20c. Location - City or Town, State Harford County Forest Hill, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of Evans Fureral Chapel and Cranation Services, Inc. 1 🗌 Burial 2 🗷 Cremation 3 🗀 Removal from State Friday Dec 14, 2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensea Jeffrey L.Cair, Sr. F. F. 2. Name and Address of Facility
Peaceful Alternatives Funeral and Cremation Center, P.A.

Lic.#M00677 2325 York Road Timonium, Maryland 21093–2215 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final 5178 Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** 1-m201 Gaquentiany not conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed ig physician and as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: page 2 should be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No 1 Yes 2 g Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 2 🗆 No 2 1 No 1 Yes 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospita 2 🗆 🕇 Other: ပ 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined To the Hospital o within 24 hours aff To the Funeral Di Medical 29a. Certifier 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifij

State

GABA, WINSOME

DHMH 17 Rev 06-2011

Registrar

MEDICAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MMONE

Date filed (Month, Day, Year)

8 2012

WASHINGTON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and Mental Hygiene 1- State State Registrar Certificate of Death Reg. No. 2012 40967								
			Registrar 1. Decedent's Name (First, Middle, Last)	Cert	rificate of Dea	ith			12		
	Physicia	n/					Date of Dea Month		Year	3. Time of Death	
	Medic		Edwin J. Geisendaffer, Sr 4a. Facility Name (if not institution, give street and number)	•	4h City Town or Loca	December 13, 2012 10:00 PM					
	Examin	er	1204 Hillsboro Ct.		4b. City, Town, or Location of Death Fallston			4c. County of Death Harford			
	Funeral			per 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth					9. Birthplace (State or Foreign		
	Director		212–36–7022 1 XM 2 □ F	72 Yrs.	Months Days Ho	ours Min.	(Month, Day March 11,		Maryla	Baltimore	
	id now at	_	Usual Residence of Decedent 10a, State 10b, County 10c, Ci	ity, Town or Loca	ation					Od. Inside City Limits	
	arylar la-fsl ified	Director	Maryland Harford Fallston							1 ☐ Yes 2 💢 No	
	or 28 e not		10e. Street and Number	<u> </u>	10f. Zip Code			10g. Citizen of \	What Count	ry?	
3	with s 23a ust b	Funeral	1204 Hillsboro Ct.		21047			U.S.A.			
	death item		11. Marital Status 12. Was Decedent Ever in U. Armed Forces?	1f	as Decedent of Hispani Yes, specify Cuban, Me	ic Origin? (Specexican, Puerto P	ify Yes or No- lican, etc.)		e - America k, White, e		
36	after II", or xamii	To Be Completed by	1 Never Married 2 Married 1 No 195		☐ Yes 2 🕅 No Sp	ecify:		Specify.			
9	atura cal E		15. Decedent's Education	16a, Decede	ent's Usual Occupation			16b. Kind of B			
215	n 72 l an "r Med		(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		(Give kind of work done during most of working life. DO NOT use retired)			,			
21	l withi		5+	Electr	<u>ical Engineer</u>			Manufact	uring_		
nd	e filed ital Hy ed oth even		17. Father's Name (First, Middle, Last)				_	Maiden Surname	e)		
Z	uld by d Mer mark natic		Lawrence Geisendaffer	1		elma Stri		0" T 6			
Ma	2 sho th and 27 is u		19a. Informant's Name/Relationship (Type, Print) Mirs. Roberta A. Geisendaffer (Spouse)	1	Address (Street and N				itate, ZIP C	ode)	
ē,	I and I Heal		20a. Method of Disposition 20b.	Place of Dispos	sition (Name of		ate	20c. Location -	City or Tov	wn, State	
mo	age fent of nt: If in y or		1 23 Bunai 2 - Clemation 3 - Removal nom State		atory or other place) ch Cemetery	Dec. 18	3. 2012	Bel Air, 1	Marvla	m	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.		21. Signature of Funeral Service Licensee Jeffrey R. Territoria								
<u>m</u>	o a L o		LIEMEN LESTERANT ("DI.	$3431 \mid 3$	Newbort Drive	. Forest	<u>НіЦ, Ма</u>	ryland 21	050	ALL	
			23a. Part 1 Enter the disease, or complications that caused the dea shock, or heart failure. List only one chuse in hach line. Immediate Cause (Final	th. Do not enter	-			est,		Approximate Interval Between	
	hysician/		disease or condition	oatt	c Ca	nce	1			Onset and Death/	
	Medical Examiner		resulting in death) Due to (or as a consection)	quence of):					1		
		er	Sequentially list conditions, if any, reading to infinediate	illende offi	firs (2)						
	ted Insit	Examiner	cause. Enter Underlying Cause (Disease or injury								
	execu in and ial-tra	Ĕ	that initiated events resulting in death) Last Due to (or as a consequence of):								
90	ath certificate be executed attending physician and for use as the burial-transit	dical	d								
876	tificat ng ph	Mec	IF FEMALE:					T			
Box 687	th cer ttendi or use	Physician/Me	23b. Was decedent pregnant 12b. Was decedent pregnant 12b. Live Birth 12b. Fei	tal death 3 🗌	I death 3 Ectopic pregnancy			23d. Date of Month			
Во	the a	ysic	1 Yes 2 No 4 Pregnant at time of 9 Unknown	Other (specify)	7						
P.O.	requires that the dea been signed by the a should be detached		Part II. Other significant conditions contributing to death but not re	sulting in the ur	nderlying cause given in	Part I.	23e. Did to	bacco use cont	ribute to the	e cause of death?	
S, I	lires t sign lid be	ed by	tly ρertension 1 □ yes 2 ₽No						3 ☐ Probably 4 ☐ Unknown		
ord	v requ	olete	LUL DON DE PRICA 24a. Was an						24b. Were autopsy findings available prior to completion of cause of		
							autop perfor 1 \(\sum \) Yes	rmed?	death?		
alF	ian: T rtifica ctor, p	BeC	25. Was case referred to medical examiner?		26. Place o	of Death (Check					
ξ	hysic his ce Il dire	70	1 Yes 2 No Hospital. 1 Inpatient 2		Other: 4	☐ Nursing Hor	ne 5 A Resid	ence 6 🗆 Oth	er (Specify)		
ιof	ing P Vfter ti funera	ate:	27. Manner of Death 1 Natural 5 □ Pending 28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work?		8d. Describe h	ow injury occurr	ed		
sior	death.	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	nome farm stre	M 1 ☐ Yes		28f Location /S	treet and Numb	er or Rural	Route Number	
<u>X</u>	l or A after Direct		4 Homicide determined building, etc. (Special					. Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	ica	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							id.	
	he Hc lin 24 he Fu	Medical	(Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. The control of the cause o								
	Vith vith com		29b. Signature and title of certifier	m>	29c. License num	nber 50	27	29d. Date signe	d Month, E	lay, Year)	
2	1/10		·	110	1	~ VO	XT	104	17/	12	
	GX V		30. Name and address of person who completed cause of death (Itel	m 23a) (Type, Pi	rint) Char	Q INOD	to D	RI	161	r M72/84	
	Sta	e	31. Date filed (Month, Dal, Year) 32. Registrar's Sign	ature	per CIUS	et-follow	4 11			11111/-1-1	
	Registr		31. Date filed (Month, Daly, Year) 32. Registrar's Sign	aves							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Joseph Thomas Gurganious Sr. 1:34 December 2012 P. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours **Director** 244-20-7241 1 □**X**M 2 □ F July 5, 1925 87 North Carolina Usual Residence of Dece 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Funeral Director notified 1 🗌 Yes 2 🎗 No Bel Air Maryland Harford 10f. Zip Code ò 10e. Street and Numbe 10g. Citizen of What Country? must be 23a 313 Wakefield Place 21014 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ral", or iten Examiner Black, White, etc. þ 1 Never Married 2 Married 1X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: "natural", Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the Mechanical Engineer U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Rodney Herman Gurganious Victoria Kenan Kenan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 Health tem 27 Parthenia Gurganious / Wife 313 Wakefield Place, Bel Air, Maryland 21014 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date . ∓ **₽** cemetery, crematory or other place) ☑ Burial 2 ☐ Cremation 3 ☐ Remova from State Department o Important: If any injury or once, Donation 5 Other (Specify) Air Memorial Gdn. 12/18/2012 Bel Air, Maryland ture of Fune 22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, MD 21014 231. Part 1. Enter the disease, or compli Approximate shock, or heart failure. List only one call n each line Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year 1 Yes 2 L 9 Unknown the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 autopsy perform After this certificate 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work s after death. 1 Tes 2 No Accident

Accident

Suicide

Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a To the Funeral I Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Skal Upper Chapapeake Drive, Belaic, mp 21014 10 Registrar

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	Please amend	Type or Print in Bla item 18 per in 9 State of Maryland / 7 per in g939 5-1	ck Indelible Ind	Ensure All Copie	es Are Legible.	
	1- For state amend item Registrar	7 per fh g939 5-1	Certificate of D	Death	Reg. No. 2012	40969
Physician/	1 Decedent's Name (First, Middle, La			2. Date of D		3. Time of Death 8:104 M
Medical Examiner		1 11 .	4b. City, Town, or	Location of Death	4c. County of Death	
Funeral		nev Hospice Sex 7. Age (In yrs. last bi	irthday) If Under 1 Year	If Under 24 Hrs. 8. Date of B		nplace (State or Foreign
Director	219-25-46-18 Usual Residence of Decedent	1 ⅓M 2 □ F 74	Yrs. Months Days	Hours Min. (Month, E 8-19	2000	nidad
yland f show ed at			wn or Location			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
the Maryland or 28a-f sho e notified at	10e. Street and Number	109/	Jimore 10f. Zip Code		10g. Citizen of What Cou	
tems 23a cer must be	614 E. 41st	12. Was Decedent Ever in U.S.		2/3/8	USA 14. Race - Amer	ican Indian
0 19	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	If Yes, specify Cuba	spanic Origin? (Specify Yes or Non, Mexican, Puerto Rican, etc.) Specify:	Black, White	
5-00% hours a hours a lical Explicated	3 Widowed 4 Divorced 15. Decedent's	Year or Dates. Education 16	6a. Decedent's Usual Occup	ation	16b. Kind of Business/I	ndustry
Maryland 21215-0036 2 should be filed within 72 hours after the and Mental Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam. To Be Completed by	(Specify only highest g	College (1-4 or 5+)	(Give kind of work done of life. DO NOT use retired)	_/	0:1 00	m cany
filed with all Hygier d other the event, the CBA	17. Father's Name (First, Middle, Last)		401minist	18. Mother's Name (First, Middl	e, Maiden Surname) Litta Herbert	, young
Marylanc 12 should be file lith and Mental h 27 is marked of rtraumatic eve	19a. Informant's Name/Relationship	Type Print) 1	9h Mailing Address (Street	and Number or Rural Route Numi	TITIOGI	
Ma 2 sh and 2 sh and 2 sh and 2 sh and 27 is	Vena Gibbs/	Wife 4	014 E. 41st	Street, Bal	timore, m	1)21218
altimore, mit. Page 1 and partmet of Hee portant: If item y injury or othe	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	Removal from State	of Disposition (Name of tery, crematory or other place MA +10N (e)	/	20c. Location - City or Han Over,	
Baltii Permit. P Departm Importar any injur	21. Signature of Funeral Service Lice			ss of Facility Vaugh, C.	Greene Funer	a Services
— 20 = 60	23a. Part 1. Enter the disease, or col	mplications that caused the death. Do	not enter the mode of Tyin		arrest,	Approximate
- Pnysician	shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.	prostal	auth n	nets	Interval Between Opset and Death
Medical Examiner	resulting in death)	Due to (or as a consequence	e of):			
(22) Ue (Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to for as a consequence	a-ofy:			
6 5 5 1_		C. Due to (or as a consequence	e of):			
68760 sertificate be ding physic use as the bu		■ d				
Box 68760 death certificate be of attending physicial definities as the burst circums as the burst circum and the definition of the burst circum and the bur	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy		су	23d. Date of del Month	ivery Dav Year
O. Box 68760 It the death certificate be at by the attending physicic etached for use as the buyerician/Medica	1 Yes 2 No 9 Unknown	4 Pregnant at time of death 9 Unknown				
		contributing to death but not resultin	g in the underlying cause gi		d tobacco use contribute to ☐ Yes 2 ☐ No 3 ☐ Pr	
Records, P. The law requires the cate has been signed, page 2 should be d				24a. W	as an 24b. Were autopsy prior to d	topsy findings available completion of cause of
ital Reccinician: The law certificate has rector, page 2:		·	ne D	1 🗆 Ye	rformed? death?	2 🗆 No
Sion of Vital Sion of Vital Attending Physician: releath, sctor. After this certific by the funeral director, difficate: To Re	examiner? 1 Yes 2 A No	Hospital:	Outpatient 3 DOA Oth	lace of Death (Check only one) er: 4 Nursing Home 5 Re	esidence 6 Other (Spec	TY HODDICE
on of or of	27. Marina of Death 1 Natural 5 Pending 2 Accident Investigati	(Month, Day, Year)	o. Time of 28c. Injury work	y at ⟨? Yes 2 □ No	e how injury occurred	
ivision of or attending P after death. Director: After t in by the funer.	3 ☐ Suicide 6 ☐ Could n 4 ☐ Hornicide det nine	290 Place of Injury . At home	farm, street, factory, office		n (Street and Number or Rui Town, State)	al Route Number,
Division of Vital Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director. Medical Certificate: To Re	29a. Certifier 1 Certifying Pt (Check 2 Medical Exa	nysician: To the best of my knowledge miner: On the basis of examination and	d/or investigation, in my opini	on, death occurred at the time, dat	e and place, and due to the	cause(s) and manner stated.
To the I within 2 To the I complex	29b. Signature and fittle of certifier	urse Practitioner: To the best of my kn	numledge, death occurred at 29c. Licens		29d. Date signer (Month	
	30, Name a ridgiress of grason who	Alfae 1	W// D/	30/2	12/16/	12
りV	JOHNTIVI	completed use of high (Item 23	Charles	91, Sill	0,11112	2/2/8
State Registrar	4 0 001	32. Registrar's Signature	pare			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 201 Arlene Elizabeth Garrett 2:31p Medical Dec 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Longview Nursing Home Carroll Manchester 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Funeral 8. Date of Birth Days Hours (Month, Day, Year) Country) 168-14-3383 Director 91 1 □ M 24 F Yrs. Nov. 10,1921 Penn. su omer man "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County fliad within 72 hours efter deeth with the Merylend 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2 X No Carroll Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2514 Hanover Pike 21074 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Completed 3℃Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Registered Nurse Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) a 1 end 2 should be fliar of Health end Mantel H f Item 27 is marked of r other traumatic ever Edward Cramer Lydia Sotdorus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley C. Lehr - sister 2145 Jefferson Rd. Spring Grove, 17362 PA. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pega 1 e
Dapartment of H
Important: If Ite
any Injury or oth Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity U.C.C. Cem.Dec. 19,2012 Manchester, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel P.A AX 3296 Charmil Dr. Manchester, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 18avs Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Examine Due to (or as a consequence of) Hospital or Attending Physician: The lew raquires that the deeth certificete be axecuted attending physicien and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Dav 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe After this certificeta 1 Yes 2 No within 24 hours after deeth.

To the Funeral Director: After this certific completaly filled in by the funaral director, Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: မူ 1 ☐ Yes 2 🖼 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 037573

State

Registrar

Name and address of person who complete

31. Date filed (Month, Day,

NEC

1204

2613

Salisbury

of death (Item 23a) (Type, Print) Po

MD

32. Registrar's Sig

7, Rell

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Harry Edward Gates December 4, 201^{Y2} 5:39 Ρм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 7. Age (In vrs. last birthday) Days Hours 578-22-6106 **Director** 1 ፟ M 2 ☐ F 86 March 25, 1926 Washington, D.C. Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 28a-f Maryland Montgomery Silver Spring 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2713 Emmet Road 20902 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give WW TT 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 6 þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No Specify. If Yes, Give Year or Dates. WW II Specify: White Completed 3 X Widowed 4 ☐ Divorced 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) end Mental Hygiene. is marked other tha Deputy Fire Chief D.C. Fire Department Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hazel Koch James Henry Gates 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health e David Alan Gates/Son 2713 Emmet Road, Silver Spring, Maryland 20902 20a. Method of Disposition 20b. Place of Disposition (Name of Monic gometery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. December 1 Burial 2 Cremation 3 Removal from State Bethesda, Maryland 14, 2012 4 Donation 5 Other (Specify) Crematorium, Inc. 21. Signature of Fungral Service Licensee R^{22 Name and Address of Facility}
Robert A. Pumphrey Funeral Home/Rockville, Inc M00198 BOO West Montgomery Ave., Rockville, Maryland 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Cardiopulmonary Arrest Medical Due to (or as a consequence of) Examiner Atrial Fibrillation Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Acute Renal Failure The lew requires that the death certificate be executed physician and s the buriel-trans that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Chronic Obstructive Pulmonary Disease Records, P.O. Box 68760 for use as IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death signed by the e 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Congestive Heart Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown certificate has been signector, page 2 should 1 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 2 🗆 No 1 🗌 Yes Division of Vital Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ٥ 2 🔀 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 X ER/Outpatient 3 I DOA 24 hours after death, Funeral Director: After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 \square Pending 2 Accident 1 Tes 2 🗌 No Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ģ Location (Street and Number or Rural Route Number, City or Town, State) determined filled in Medical 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) manica D66372 December 5, 2012 101 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, Maryland 20910 Majid Rahmanian, M.D. 31. Date filed (Month, Day, Year) State

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Registrar

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			For State Registrar	01010 01 1111	ar y rar .			te of D			-	Reg. No	0016	2 1.00	772
	Dhuniaia	/	1. Decedent's Name (First, Middle, Las	t)							2. Date of De	ath	<u>C. U 1 1</u>	3. Time of I	Death
	Physicia Medic			over							Month Decembe	r 1	2, 2012	11:20	рМ
	Examin	ier	4a. Facility Name (if not institution, give 8201 Hamilton Spr	ing Court			Вe	thesd					. County of De Montgor		
	Funeral Director		5. Social Security Number 6. Se 557–26–3091	x 7. Age XIM 2 □ F	e (In yrs. I	ast birthday)	If Und- Months	Days	If Under 2	4 Hrs Min.	8. Date of Bin (Month, Da			irthplace (State or ountry)	Foreign
			Usual Residence of Decedent	A 2	89	Yrs.					May 16	, 19	023 Ca	lifornia	
	s filed within 72 hours after death with the Maryland tal Hygiene. 3d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Director	10a. State 10b. County			y, Town or Loc								10d. Inside City	
	or 28;	Dire	Maryland Montgome 10e. Street and Number	i y	Бе	thesda		ip Code	-			10a. Ci	tizen of What C		2 111 110
	with t	Funeral	8201 Hamilton Spri	ing Court			2	0817			ì	U.S		, .	
	death items		11. Marital Status	12. Was Decedent E	ver in U.S	S. 13. V	Vas Dece	dent of Hi	spanic Origi n, Mexican,	n? (Spec	ify Yes or No-		14. Race - Am Black, Wh		
36	after al", or	d by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ፟ Yes 2 ☐ If Yes, Give Year or Dates.	No WW]	,			Specify:				Consifu	hite	
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22	ed with Hygier other i	6)	17. Father's Name (First, Middle, Last)	5+		Syste	ms A	nalys		J. N.	Cinca A A Codella		puter S	science	
ğ	ental Hy ental Hy e ed oth	2	Fred Jared Groven	•					Iren		(First, Middle, lair	Maiden	Surname)		
ary	should le fil n and Mental 7 Is maried (reumatic eve		19a. Informant's Name/Relationship (Ty			19b. Mailin	g Addres	s (Street a	and Number			r, City or	Town, State, 2	Zip Code)	
≥,	Fred Jared Grover 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cook Beverly Rose Grover / Wife 20a. Method of Disposition 20b. Place of Disposition 20b. Place of Disposition 20c. Location - City or Town											1D 20817			
Baltimore, Maryland 21215-0036	Page 1 anent of Hant. If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	0	Place of Dispo emetery, cren tgomery	natory or	other place	' i D		ber 14		ocation - City o thesda.	or Town, State Mary1an	d
Balt	permit. Page 1 Department of Important: If it any injury or o		21. Signature of Funeral Service License		MOIO	22	. Name a	nd Addres	s of Facility			,		la-Chevy Cl v1and 20	
			23a. P 1. Enter the disease, or comp shock, or heart failure. List only or	lications that caused the cause on each line	the deat									Approximate Interval Betw	
- 1	Physician/ Medical	1	Immediate Cause (Final disease or condition resulting in death)	a Cerebr			Hemo	rrhag	ge					Onset and De	
1	Examiner		resulting in death)	Due to (or as a			D4							10 yea	
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376	ficate g phys as the			d											
Box 6876	h certi tendin or use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome			Ectopic	pregnanc	٧				23d. Date of d	elivery	
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s, P.(ires that signed Id be de	Ď	Part II. Other significant conditions co	ntributing to death be	ut not res	ulting in the u	nderlying	cause giv	en in Part I.					to the cause of dea	
ord	w requ	Completed									24a. Was		24b. Were a	utopsy findings av	/ailable
Rec	The le ate ha	Som									autor perfo 1 Yes	osy rmed? 2 K N		completion of car es 2 \(\subseteq \text{No} \)	use of
tal	clen: ertific ector,	Be	25. Was case referred to medical examiner?	lospital:					ace of Death	(Check					
Ž	Physic this carral dir	. To	1 ☐ Yes 2 ☒ No 27. Manner of Death	1 Inpatie		ER/Outpatien		Othe 28c. Injury	4 ∐ Nurs				Other (Spe	ecify)	
ion o	tending leath. or: After the fune	Certificate:	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day		injury	M	work'	Yes 2 □ N		8d. Describe h	iow injur	y occurred		
Division of Vital Records, P.O.	To the Hospitel or Attending Physicien: The lew requires that the death certificate within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the		4 Homicide determined	28e. Place of Inju building, etc			eet, facto	ry, office		2	8f. Location (S City or Tow			ural Route Numbe	r,
	he Hosp in 24 hou he Funei pletely fl	Medical	29a. Certifier 1 X Certifying Phys (Check 2 Medical Examination only one) 3 Certifying Nurs	ner: On the basis of ex	amination	n and/or invest	igation, ir	my opinio	n, death occ	urred at 1	he time, date a	nd place	, and due to the	cause(s) and man	ner stated.
	Tot Com		29b. Signature and title of certifier	Kal	11	1	29	c. License —DC25					te signed <i>(Mon</i> ember 1.		
	12x/M		30. Name and address of person who co												
	1		Raymond Scalettar 31. Date filed (Month, Day, Year)	M.D. 3	Was	hingto	n Ci	rcle,	, Ste#	303,	NW, W	ashi	ngton,	DC 2003	/
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State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	`	State of Ma	arylanu	•	tificate o			entarriye	Reg. Na 2 0	12	40973
	Dhamisis		Decedent's Name (First,	Middle, Last)							2. Date of Dea	th	Year	3. Time of Death
	Physicia Medic	al .	PHYLLIS		ENDLER		GLA	ASSMAN			December		2012	305 pm M
	Examin	er	4a. Facility Name (if not inst					4b. City, Tow				4c. Coun	ty of Death	'
أتحديث	Funeral		UNION MEMOR 5. Social Security Number	6. Sex		(In yrs. last	birthday)	BALT:	ear If U	Inder 24 Hrs.	8. Date of Birti	h	9. Birth	nplace (State or Foreign
	Director		214-26-3024	1 🗆 N	м 2 🕅 F	0.	Yrs.	Months Da	iys Ho	urs Min.	(Month, Day		Cou	ntry)
	D A		Usual Residence of Deceding 10a, State 10b, C			8: 10c. City, T		ation			03/09	/1929	1	MD 10d. Inside City Limits
	rrylan Ied a	Director		ŕ	_									1 ☐ Yes 2 🎇 No
	or 28a notif		MD B	ALTIMOR	.E	PIR	KESVII	10f. Zip Cox	de			10g. Citizen o	f What Cou	untry?
	with the 23a of 1st be	Funeral	3198 OLD 1	OST DR	IVE, #2			212	08			USA		
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36	after or I", or xamir	d b	1 Never Married 2		1 Yes 2 X	No	1	☐ Yes 2 🛚				Speci		
ဝို	atura cal E	Completed	15. D	ecedent's Educa		-	16a. Deced	ent's Usual Oc	cupation			16b. Kind of		
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and	ntal H red of	일	17. Father's Name (First, M. SAMUEL	iddie, Last) W		HEND	TED			Mother's Name	e (First, Middle,	Maiden Surna	me) SHAP	TRO
Ž	ould to	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street Route Number, City or												
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ore,	of Her		20a. Method of Disposition 1 X Burial 2 ☐ Crer			20b. Plac	e of Disponetery, crem	sition (Name o	f place)	С	Date	20c. Locatio	n - City or	Town, State
Ĕ	. Page ment tant: I		4 Donation 5 0	Other (Specify)	movar nom state	AR CH	TZUK_	natory or other ON CEM AMUNO	CONG	112/10	5/2012			E, MD
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Se	rvicedicen			22	. Name and A 8900 R		50.	L LEVIN ROAD,			, INC. MD 21208
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause our ach line.											Approximate Interval Between		
, -	nysician/	3	Immediate Cause (Final disease or condition	,	Seps	1)							- 1	Onset and Death
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89	certific nding use as		IF FEMALE: 23b. Was decedent pregna	int 23c	c. If yes, outcome			le				23d.	Date of del	ivery
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S, P.	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	d by									1 🗆	1/		robably 4 🗌 Unknown
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tal	cian: ertific ector,	Be	25. Was case referred to mexaminer?	10	spital: \/			2	6. Place of	of Death (Check	(only one)			
Ž	Physic this caral dir	2	1 Yes 2 7No 27. Manner of Death		1 Inpati 28a. Date of inju		R/Outpatier 8b. Time of	nt 3 DOA	Injury at	☐ Nursing Ho	me 5 Residence 128d. Describe I			ify)
on C	nding ath. r: After	icate		Pending Investigation	(Month, Da	y, Year)	injury	- 1	work?	2 🗆 No				
Division of Vital Records, P.O.	or Atte after de Directo	Certificate:	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	28e. Place of Injubul	ury - At hom c. (Specify)	e, farm, str	eet, factory, of	fice		28f. Location (S City or Tov		nber or Rui	ral Route Number,
Δ	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	(Check 2 Me	edical Examiner	an: To the best of r: On the basis of e	xamination a	and/or inves	tigation, in my	opinion, d	eath occurred at	t the time, date a	and place, and	due to the	cause(s) and manner stated.
	o the l	Me	only one) 3 Ce 29b. Signature and title of	ertifying Nurse F	Practitioner: To th	e best of my	knowledge	, death occurre	d at the tir	me, date and pla	ace, and due to	the cause(s) an 29d. Date sig	d manner a	s stated.
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			30. Name and address of	person who com	pleted cause of c				Q	11.	10 c:	210		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40974 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December Day 7, 2012 10:30p M Beulah Hennrich Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Glen Burnie Marley Neck Health and Rehab 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Hours Director 92 094-18-7333 1 🗆 M 2 💢 F Dec. 11, 1920 Towa Usual Residence of Dece 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location the Maryland ms 23a or 28a-f sho must be notified at Director 1 Yes 2 X No Pasadena Marvland Anne Arundel 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code Funeral with United States 21122 221 Beach Road items ; Page 1 and 2 should be filed within 72 hours after death . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11 Marital Status Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner. Armed Forces 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Completed by Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☐ No Specify. 3 ♥ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Own Home Home Maker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Mabel Hostetler Yoder Jonathan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 221 Beach Road, Pasadena, Maryland 21122 Mary Ann Wood / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 12/18/2012 Baltimore, Maryland 21. Signature of Euneral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland, Inc. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on earlie. 299 Frederick Road Baltimore, Maryland 2<u>1228</u> Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Due to (or as a consequence or): if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami burial-trai Due to (or as a consequence of): resulting in death) Last physician Be Completed by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as t attending IF FEMALE: ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ Live Birth 2 - Fetal death for in the past 12 months? Month Day Pregnant at time of death signed by the a 2 🗌 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has performed? Yes 2 No 1 Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: injury Natural 5 Pending 1 \(\text{Yes} 2 🗌 No Investigation Accident within 24 hours after death

To the Funeral Director: / 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 3 [29b, Signature and title of cert

10V

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Chopra

1 8 2012

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 18 per fh g934 12-18-12 yt. State of Maryland / Department of Health and Mental Hygiene 40975 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 12, 2012 9:55 P Hutchins Adele R. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Riderwood Village Nursing Center Montgomery If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth Funeral Days Hours (Month, Day, Year) Director 578-24-9834 1 M 2XXF 88 June 22, 1924 Washington DC Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Examiner must be notified at Director MD 1 Yes 2 No Montgomery Silver Spring 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 23a Funeral United States 3114 Gracefield Rd. #WC518 20904 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XX No 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3XWidowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Public Schools Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked of ဥ Page 1 and 2 should be Reese Lucile (Unknown) other traumatic Lester Knapp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Loraine Hutchins / Daughter 8606 Barron St., Takoma Park, MD 20912 Department of Healt Important: If item 2 any Injury or other 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Chesapeake Crematory 12/17/2012 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service NO 382 Rapp Funeral and Cremation Services the Colinsein 933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 3 DAYS Immediate Cause (Final Physician/ INTESTINAL OBSTRUCTION disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ADHESIONS INTESTINAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Be Completed by Physician/Medical al or Attending Physician: The law requires that the death certificate be after death.

I Director: After this certificate has been signed by the attending physicis P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Pregnant at time of death 9 Unknown After this certificate has been signed by the functional director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2√No 3 ☐ Probably 4 ☐ Unknown Records, 1 🔲 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) examiner? Other: 4XXXNursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1 🗌 Yes 2XX No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred XIX Natural
2 Accident
3 Suicide 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Hospital Medical 29a. Certifier 1 XX certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title welchen 29c. License number 29d. Date signed (Month, Day, Year) D36716 DECEMBER 13, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KUNDRAT, M.D.: 3110 GRACEFIELD RD., SILVER SPRING, MD 20904 ANDREW G. 31. Date filed (Month, Day, Year) State 8 1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2. Date of Death Physician/ 04.304 M cente Medical 4b. City, Town, or Location of Death Examiner Baltimor N/AIf Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) . Age (In yrs. last birthday, **Funeral** Days Hours Months 216 24 5858 1 □ M 2 🗓 F Director 83 Maryland 06/30/1929 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Directo 1 X Yes 2 ☐ No N/A Baltimore Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral U.S.A. 21230 600 Light Street Apt. 620 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces?

1 Yes 2 X No
If Yes, Give Black, White, etc. 1 X Never Married 2 ☐ Married 5 Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within 72 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Monts Important: If item 27 is marked any injury or con-ပ Willard A. Hause Edith E. Gould 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Belt / Daughter 1712 Wickes Avenue Baltimore, Maryland 21230 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 12/15/2012 Baltimore, Maryland Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Fune al Service o 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Due to or as a consuluence of anding physician and use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 2 Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in the cause of examination and/or investigation in the cause of examination and/or investigation in the cause of examination and/or investigation in the cause of examination and/or investigation in the cause of examination and/or investigation in the cause of examination and or investigation and or investigation in the cause of examination and or investigation and or investigation in the cause of examination and or investigation and or inv Medical 29a. Certifier The latter of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 06-2011

State

tu, blen Bussie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ State	State of Ma	ryland		rtment tificate				/	012	40977	
			Registrar 1. Decedent's Name (First, Middle, Last)				imeate	<i>51 D C C</i>	307	2. Date of De	Reg. No.		3. Time of Death	
	Physicia Medic		Juanita	Hendry				_		Decemb	er ^{Day} 3	, 2012	2:10 P M	
	Examin	er	4a. Facility Name (if not institution, give stre		1.0				cation of Death		4c. Co	ounty of Death Baltin	noro	
	Funeral		717 Maiden Choice I 5. Social Security Number 6. Sex	7. Age	(In yrs. last	birthday)	If Under 1		Under 24 Hrs.	8. Date of Bir		9. Birth	place (State or Foreign	
	Director		337-20-9365	M 2 💢 F	83	Yrs.	Months [lays H	lours Min.	Jan. 3	0°, 192	8 Miss	ouri	
	ind show at	'n	Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Loc	ation						10d. Inside City Limits	
	Maryla 18a-f tified	Director	Maryland Baltimore	2	Cato	nsvil	1e						1 ☐ Yes 2X☐ No	
	h the l		10e. Street and Number				10f. Zip C					n of What Cou	ntry?	
	ath wit	Funeral	717 Maiden Choice	. Was Decedent Ev			212		nic Origin? (Spe	ecify Yes or No-	USA	. Race - Ameri	can Indian	
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 📆 Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 X N If Yes, Give Year or Dates.		If	Yes, specify	Cuban, N	lexican, Puerto	Rican, etc.)		Black, White,		
5-0	2 hour	plet	15. Decedent's Educ (Specify only highest grade			(Give k		one durin	n ng most of work	ing	16b. Kind	of Business In	dustry	
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d 2	filed w al Hygi I other vent, 1	Be	17. Father's Name (First, Middle, Last)			bunst	71 210		. Mother's Nam	e (First, Middle,				
ylaı	Menta Menta narked	ပ္	o o o - F	ussen					Agnes	France		rhardt		
Mai	12 shouth and 27 is n		19a. Informant's Name/Relationship (Type, James J. Hendry- S	•		19b. Mailin 5822	g Address (S N. 27	treet and th St	Number or Rura t., Arl:	ington,	r, City or To VA 22	wn, State, Zip 2207	Code)	
Baltimore,	of Hea of Hea fitem		20a. Method of Disposition 1 ☐ Burial 2 🂢 Cremation 3 ☐ Re				sition (Name natory or othe			Date	20c. Loca	ation - City or T	own, State	
timo	: Page tment tant; I		4 ☐ Donation 5 ☐ Other (Specify)	moval from State	1	intic	Crema	cory		7/2012			, Maryland	
Bal	permit Depar Impor any in		21. Signature of Funeral Service Licensee	mo123		110	30 Edn	onds	on Ave.	, Cator	ISVIII	Schwal C. e. MD	Witzke 21228	
	Physician/		23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one of Immediate Cause (Final disease or condition	ations that caused to cause on each line.	the death. [Do not ente		- 1	uch as cardiac		rest,		Approximate Interval Between Onset and Death	
	Medical Examiner		resulting in death)	Due to (or as a	consequen	ice of):								
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequen	ice of):								
	ate be executed ohysician and the burial-transit	Examiner	Cause (Disease or iinjury that initiated events c. resulting in death) Last	Due to (or as a	consequen	ice of):							-	
0	be ex sician burial	dical	d	,	•									
68760	ificate I ng phys as the	Medi	IF FEMALE:											
Box 6	To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transic.	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	If yes, outcome o □ Live Birth 2 4 □ Pregnant at □ Unknown	⊇ ☐ Fetal d	eath 3	Ectopic pre Other (spec				23	d. Date of deliving Month	very Day Year	
s, P.O.	ires that the dea signed by the a Id be detached i	ρ	Part II. Other significant conditions control	ibuting to death bu	it not resulti	ing in the u	nderlying cau	se given	in Part I.	23e. Did t	-	/	he cause of death?	
ord	law require has been si je 2 should l	Completed								24a. Was		24b. Were auto	opsy findings available ompletion of cause of	
Rec	The la	Com								1 🗆 Yes	ormed? 2 No	death?	2 🗆 No	
ital	sician; The certificate rector, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No	spital:				Othor	of Death (Chec			1		
of V	y Phys er this eral dir	e: 10	27. Manner of Death	1 ☐ Inpatie	y 28	3b. Time of		Injury at	4 Nursing He	ome 5 Resi 28d. Describe			y)	
on (ending leath.	ficat	1 Natural 5 Pending 2 Accident Investigation	(Month, Day,	Year)	injury	М	work?	s 2 □ No					
Division of Vital Records,	al or Att s after de l Directo d in by t	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	ry - At home (Specify)	e, farm, stre	eet, factory, c	ffice		28f. Location (City or To		Number or Rure	l Route Number,	
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu	Medical (29a. Certifier (Check only one) 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 **Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
	To the within To the comp	-	29b. Signature and http of certifier					icense nu				signed (Month,		
				Δ		- 1.5	D	35	325	(12-	14-9	012	
			30. Name and address of person who com	pleted cause of de	ath (Item 23	3a) (Type, P	Coch	~	ave	Balt	MOR	eMI)21229	
	Sta Registr		31. Date filed (Month, Day, Year) 8 20	32. Fegistrar	's Signature	1. 1	and						,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Betty J. Hobson Month 12 :35 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Franklin Samare Kesedale If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country)
 NC 8. Date of Birth **Funeral** 5. Social Security Number 215-32-6519 Age (In yrs. last birthday) Feb. 11, 1934 Days 78 Months 1 □ M 2 🕇 F Director or 28e-f ehov 10a. State 10b. County 10d. Inside City Limits Item 27 is merked other then "neturel", or items 23e or 28e-f eho other treumetic event, the Medical Examiner must be notified at 10c. City, Town or Location with the Meryland Director Rosedale MD Baltimore 1 Yes 2 No 10f. Zip Code 21 237 10e. Street and Number 10g. Citizen of What Country? 2 Galahad Court USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. nosqa þ 1 Never Married 2 Married Maryland 21215-0036 White If Yes, Give Year or Dates. 1 ☐ Yes 2 A No Specify: Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 nand Mental Hygiene. Elementary/Secondary (0-12) 12th College (1-4 or 5+) own home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Heelth and Menta Importent: if Item 27 is merked any Injury or other transporce Gertrude Webb Jason A. Parker Sr. Informant's Name/Relationship (Type, Print)

Garlin R. Hobson Sr./Husband 2 Galahad Court Baltimore MD 21237 19a. Informant's Name/Relationship (Type, Print) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ★ Burial 2 Cremation 3 Removal from State Gardens of Faith Baltimore MD 12/18/12 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lis 22. Name and Address of Facility 300 Mace Ave. Balto. MD Essex 21221 Connelly Funeral Home of 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreshock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition resulting in death) Respiratory Medical Due to (or as a consequence f) Examiner PErcapnic Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Lue to (or as a consequence of): ettending physicien and for use as the burial-transit e Hospital or Attending Physicien: The lew requires that the death certificate ba exacuted the Attendra death.

Funerel Director: After this certificata has been signad by the ettending physicien and lettaly filled in by the funaral director, page 2 should ba detached for use as the burial-transit interstit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ₽No မှ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work?
1 Yes 2 No 1 Natural 5 Pending 2 Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical To the Hospi within 24 hou To the Funer completaly fil 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) A92amova RES 0000 12-14-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Somare Drive, Baltimore, Mi) noza State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Hall Dav Physician/ Sandra December 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Randallstown Baltimore Seasons Hospice 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
PA 8. Date of Birth **Funeral** (Month, Day, Year) Days Hours 71 217-40-0672 1 🗆 M 2 🕇 F Director Dec. 18, 1941 Yrs Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director Brooklyn Park Baltimore MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA items 23a 21225 3rd Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: White "natural", Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Housewife 12th Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any priary or other traumatic even once. 18. Mother's Name (First, Middle, Maiden Surname) Sylvia Havanas Samuel C. Wallace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code)
3 3rd Ave Brooklyn Park, MD 21225 Rick Hall (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Holly Hill Cemetery 12/17/12 Baltimore, 4 Donation 5 Other (Specify) 21. Signature of Funeral Service L 22. Name and Address of Facility 300 Mace Ave. Essex, MD 21221 Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final (ancer Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): e Hospital or Attending Physician: The law requires that the death certificate be executed 12 hours after death.

24 hearst libractor. After this certificate has been signed by the attending physician and letely filled in by the furnear director, page 2 should be detached for use es the burial-trensit eletely filled in by the furnear director, page 2 should be detached for use es the burial-trensit Cause (Disease of injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform Yes 2 No 1 ☐ Yes 2 ☐ No e B 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence of Other specific ent hospice 1 Yes 2 No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident Investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical To the Hospi within 24 hou To the Funer completely fil 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier

NS Kaj apachel MD 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 21209 SmIM 31. Date filed (Month, Day, Year) **IEC 1** 8 **2012** 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland	/ Department of Certificate of			0010	40980						
			Registrar 1. Decedent's Name (First, Middle, Last)	Certificate	oi Deatti	2. Date of Deat	eg. No.2012 h	3. Time of Death						
	Physicia Medic		Gary L. Hollen			Month 12/1	LO/2012 Year	5:15 P M						
	Examin	er	4a. Facility Name (if not institution, give street and number)		wn, or Location of De		4c. County of Deat							
Title	Funeral		Carroll Hospital Center 5. Social Security Number 6. Sex 7. Age (In yrs. last to the context)	birthday) If Under 1		rs. 8. Date of Birth	Carrol 9. Birt	.1 hplace (State or Foreign						
	Director		195-34-5759 1X M 2 □ F	Yrs. Months D	Days Hours M	(Month, Day,	Year) Cou	PA						
	ind show at	'n	Osual Nesidence of Decedent	own or Location			1944	10d. Inside City Limits						
	Maryla 28a-f otífied	Funeral Director	MD Carroll Syl	kesville				1 🗆 Yes 2 🔀 No						
	th the	al D	10e. Street and Number	10f. Zip Co		1	0g. Citizen of What Co	untry?						
	ath wi	nnei	6528 Freedom Ave. 11. Marital Status 12. Was Decedent Ever in U.S.		21784	(Specify Yes or No-	USA 14. Race - Amer	icon Indian						
36	nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show linjury or other traumatic event, the Medical Examiner must be notified at e.	Ď	1 ☐ Never Married 2XXMarried Armed Forces? 1 ☐ Yes 2 X No		t of Hispanic Origin? Cuban, Mexican, Pu No Specify:	erto Rican, etc.)	Black, White	e, etc.						
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lanc	should be filed with n and Mental Hygien 7 is marked other tranmatic event, the	70 E	17. Father's Name (First, Middle, Last) Robert Hollen			Name <i>(First, Middle, M</i> ne Woomer	faiden Surname)							
ary	should and M is mar	177		19b. Mailing Address (St			City or Town, State, Zip	Code)						
	and 2 s Health tem 27		Peggy Hollen/Wife			Sykesvil1	Le, MD 2178	4						
JORE	ige 1 and tot H		1 Burial 2 X Cremation 3 Removal from State ceme	e of Disposition (Name of etery, crematory or other	r place)		20c. Location - City or	,						
Baltimore, Maryland	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 once.		4 Donation 5 Other (Specify) S. C. 21. Signature of Funeral Sergio Linguistics	arroll Cren			Winfield,							
Ö	Depar Depar Impor any ir		Jall Caller	1212 V	v. 01d Lit	euneral Holoerty Rd.,	me & Cremat Winfield,	MD 21784						
			23a. Part 1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on pash line.					Approximate Interval Between						
	Medical		Immediate Cause (Final disease or condition resulting in death)	Aug Hu	perter	15:001		2 M W HW						
	Examiner		Due to (or as a consequence)	Aug Hu ce of): _nvp Slee	eo Apre	A School	LOM	Dictan						
in:	_ =	iner	if any, leading to immediate Due to (or as a consequence cause. Enter Underlying		1									
	ecutec and -trans	Examiner	Cause (Disease or injury that initiated events c	ce of:										
0	be ex sician buria	cal	d d											
876	tificate ng phy as the	Medi	IF FEMALE:											
Box 687	th cert ttendir or use	ian/	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal de	eath 3 🔲 Ectopic preg			23d. Date of deli	very Day Year						
B	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Medical	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown	th 5 U Other (special	ty)		MORE	Day Teal						
О	that the	by PI	Part II. Other significant conditions contributing to death but not resulting	ng in the underlying caus	se given in Part I.	23e. Did tob	acco use contribute to	the cause of death?						
ds,	equires sen sig rould b	ted	morpid obesity			1 ½ Ye	s 2 No 3 Pr	obably 4 🗆 Unknown						
Records,	The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transi	Completed				24a. Was an autopsy perform	y prior to c	opsy findings available ompletion of cause of						
m m	sician: The law i certificate has t irector, page 2 s	Be Co	25. Was case referred to medical		26. Place of Death (C	1 Yes 2	☑No 1 ☐ Yes	2 No						
<u> </u>	nysicia nis ceri I direct	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/		Other:		nce 6 Other (Speci	fy)						
סר	iing Pi		1 ☑ Natural 5 ☐ Pending (Month, Day, Year)	injury	Injury at work?	28d. Describe hov	v injury occurred							
Sior	Attend r death ctor: / cy the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be		1 Yes 2 No	28f. Location /Str	eet and Number or Run	al Route Number						
Division of Vital	al or A		4 Homicide determined building, etc. (Specify)	,,,,,,		City or Town,		arriode rearriod,						
-	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledg (Check 2 Medical Examiner: On the basis of examination and	d/or investigation, in my of	opinion, death occurre	ed at the time, date and	I place, and due to the c	ause(s) and manner stated.						
	Fo the within (Fo the comple	ž	only one) 3 Certifying Nurse Practitioner: To the best of my kn 29b. Signature and title of certifier	nowledge, death occurre		d place, and due to the		stated.						
	, , ,		John Gola	Ein -	D3166	C	12/10/12							
	6V		30. Name and address of person who completed cause of death (Item 23a	a) (Type, Print)	04 010	14 1 200	74	W GA VALA						
	Stat	0	31. Date filed (Month, Day, Year) 32. Registrar's Signature	K71MIN ZI	TO MAN	4/200 2115	1 114/12	N. CALMYA						
	Registra		30. Name and address of person who completed cause of death (Item 23a 2 5 5 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	parker										
			242	* 27										

JONA THAN 12-09481 Unk Unk Micuaer | How Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 4098 | State of Maryland / Department of Health and Mental Hygiene

			I- For State Registrar		Certific	ate of L	Death			Reg. No			
	Physicia		Decedent's Name (First, Middle,La	st)					2. Date of Month		Year	3. Time of Death	
Medic	al Exami		Jonathan Michae						Dece	mber 13,	2012	0444 hrs	
,	•		4a. Facility Name (if not institution, gi					or Location of D	eath		c. County of D	eath	
			Gambrill Park Road north	of High Knob			Frederick				Frederick		
	Funeral		5, Social Security Number 6, 8	Sex 7. Age (In yrs. last bir	thday)	If Under 1 Ye	_		of Birth (MM		. Birthplace (State or oreign	
	Director		214-29-9833	X M 2 F	22	Yrs.	Months Da	ays Hours	Min. Jur	ne 12,		Country) Maryla	and
		<u> </u>	Usual Residence of Decedent										
	any	Γ	10a. State 10b. County	11	0c. City, Town	or Location	1					10d. Inside City L	
	nd shnw	_	MD Freder	ick			Frede	rick				1 X Yes 2	No
	ne Maryland or 28a-f shnw fied at once.	돯	10e. Street and Number			T	10f. Zip Code			10g. Cit	tizen of What	Country?	
	he M	Director	1208 Ardmore Cou	rt #17			2	1703		In	ited St	tatos	
	hours after death with the Maryland natural", nr items 23a or 28a-f shn Examiner must be notified at once		11. Marital Status	12. Was Decedent E	ver in U.S.		Decedent of I	Hispanic Origin		or No-	14. Race - A	merican Indian, Black,	
	item item	Funeral	1 X Never Married 2 Marrie	Armed Forces?	No	If Yes	i, specify Cub	an, Mexican, P	uerto Rican, et	c.)	White, et	C.	
			3 Widowed 4 Divorce	d If Yes, Give Year 201		1 N	es 2 X N	No specify:			Specify: V	White	
	led within 72 hours after Hygiene. In ther than "natural", the Medical Examiner.	ğ	15. Decedent's Education (Specify		leted) 16a.			oation (Give kin		16b.	Kind of Busine	ess/Industry	
	2 3	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during mos	t of working li	ife. DO NOT us	e retired)				
3.6	within rene. cr tha	ם	12		D	elive	ry Per	son		F	ood Sei	rvice	
Š	lygien nthen the M	3	17. Father's Name (First, Middle, Las	t)				18.Mother's I	Name (First, M	iddle, Maider	n Surname)		
7	2 should be filed within and Mental Hygiene. 27 is marked nther that matic event, the Media	Be	Christopher Rob	ert Horne				Marth	a Jear	n Mer	edith		
2	2 should the and Mer 27 is man	2	19a. Informant's Name/Relationship	Type, Print)	19	b. Mailing A	Address (Str	eet and Numbe	er or Rural Rou	te Number, (City or Town, S	State, Zip Code)	
MD 21215-0036	27 is		Christopher R. H	orne / Fath				Shop Rd	. Mt.	Airy,	MD 21	1771	
	t te leal an		20a. Method of Disposition 1 Burial 2 X Cremation 3	Demoual from State		of Dispositi tory or othe	on (Name of or place)	cemetery,	Date	20c.	Location - Cit	ty or Town, State	
Š	ages ant of tr. I		4 Donation 5 Other Specif			ourne	v Crem	atory 1	2/17/2	012	ridboow	ne, Marylar	ьn
Raltimore	permit. Pages l Department of F Important: If injury or other	1	21. ature of Funeral Service Lice			22. Na	me and Addre	ess of Facility					.id
ď		- 3	Heury & H	a With	MO125	GO1: 1 Bev	ng Hom erly L	e Crema Heckr	tion Se	ervice A Cla	rksvil	Box 784 le, MD 2102	29
Р	hysician	-	21a. Fart I. Ent the disease, or com		e death. Do n	ot enter the	mode of dyir	ng, such as card	liac or respirat	ory arrest, sh	nock, or heart	Approximate Inf Between Onse	nterval
	/Medical		failure, Liff only one cause on e	each line. Multiple Injuries								Death	t and
	xaminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conseq	uence of):								
			Sequentially list conditions,).									
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	_	Examiner	(Disease or injury that initiated	Due to (or as a conseq	uanca of):						_		-
	ed nsit	Exa	events resulting in death) Last	d.	dence or).								
	cate be executed physician and the burial - transit	Medical	UNPENDED	AMENDED									
760	e be e ysicia buria	edi		23c. If yes, outcome	of monanana					2	3d. Date of del	livery	
276	ificating physical section is the		IF FEMALE: 23b. Was decedent pregnant in the	1 Live birth			I death	3 Ectopic p	regnancy	2	Month	Day Year	ır
2	eath certific e attending for use as t	cia	past 12 months?	4 Pregnant at tii			er (Specify)						
Rox 68	e death the att	Physician	1 Yes 2 No 9 Unknow	^{/n} 9 Unknown									
	at the		Part II. Other significant conditions	contributing to death t	out not resultin	ng in the un	derlying caus	e given in Part				te to the cause of death	
Δ	res th signed be de	d by							_ 1	Yes 2	√ No 3	Probably 4 Unknown	iown
٥	w requir	Completed							24a	. Was an autopsy		re autopsy findings ava r to completion of caus	
5	law has e 2 st	臣							_	performed?	dea		
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4	certion recto	Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient	2 EB/C	Outpatient		1	Nursing Home		tence 6 🗸	Other: Scene	
<u> </u>	Physical different differe	잍	1 Yes 2 No 27. Manner of Death	28a. Date of Injury		Time of Inj		njury at Work?			iury occurred	yaron doone	
2	ding Ph After t funeral	ᇹ	1 Natural 5 Pending	Dec 13, 2012		0 hrs	´ l	Yes 2 ✓ N	Subjec	t driver of		ngle vehicle collis	ion;
.0	Attend r death ector: by the	läti	2 🗸 Accident Investiga	tion28e. Place of Inju	n. At home 1	form street			car car	ught fire	and Number of	or Rural Route Number	r City
Division of Vital Records P.O.	ospital or A hours after neral Dire	Certification:	3 Suicide 6 Could no	ot be			, ractory, onic	c ballang, c.c.	or T	own, State)		gh Knob, Frederick,	
-	spits hours mera y fille		4 Homicide	(Speed) Waje		-		data and alam					
	E F	Medical	(Check only Certifying Fifys)	cian: To the best of my er:On the basis of exami									
	To the within 2 To the complet	eg	29b. Signature and title of certifier	and manner stated.		-		ense number				(Month, Day, Year)	
			Loss, originates of and all of contines	(1) An-	1			C.M.E.			ecember 13		
	. 1		rgen/o	call. IN	<u> </u>		J						
K	X1/		30. Name an address of person wh	o completed cause of de Assistant Medical E		900 \//	Baltimore	Street Ral	timore MD	21223			
J	V							- Justin Dal					
	S Regis	tate	31. Date filed (Month, Day, Year)	32. Registrar's	S. Asa	Mal							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar L N 9 R 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10:24 ам 2012 December Garland M. Huffman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ceci1 Elkton. MD Union Hospital 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours **Director** 177-30-6957 82 1 **X** M 2 □ F July 18, 1930 Virginia items 23a or 28a-f show 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location Examiner must be notified at Director Mary land Ceci1 Elkton 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 605 Blue Ball 21922 Road within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No Black, White, etc 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give July 9,1951-Year or Dates 1170 White 1 ☐ Yes 2X No Specify. 3 Divorced 4 Divorced "natural" Completed the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit, Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene, Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Machine Operator Manufacturing Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Mahalia Francis John F. Huffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21922 P.O. Box 731, Elkton, MD Jerry Church / Nephew 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗶 Burlal 2 🗌 Cremation 3 🗶 Removal from State Bowmansville Union Cemetery Dec. 19,2012 Bowmansville, PA 17506 4 ☐ Donation 5 ☐ Other (Specify) Signature | Funeral Service Lic | See 22. Name and Address of Facility ^{2. Name and Address of Facility}
P.O.Box 31, 209 East Main St.
Eckenroth Home for Funerals, Terre Hill, Pennsylvania 17581 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Exami death certificate be executed conchiec Cause (Disease or injury attending physician and for use as the burial-trar that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Other (specify) signed by the and be detached for 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed?

1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: ည 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d Describe how injury occurred Certificate: 1 Natural 5 Pending Investigation Accident 3 ☐ Suicide 4 ☐ Homicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Activities a state of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check D0060756 completed cause of death (Item 23a) (Type, Print) w main St. E/kbon, MD 2/92/ oksoygan

DHMH 17 Rev 06-2011

State Registrar Bay 8

State Registrar Date filed (Month, Day, Yea

JUANITA HARTLINE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1	State Registrar		ai y idi id		tificate			urior ivi	Cittairiy	Reg. N	2012	40981	+
Physi			1. Decedent's Name (First, Middle, Las Gertrude Louise I	•							2. Date of De		2, 20 ^{Year}	3. Time of Death	\Box
Me Exan	dica	_	4a. Facility Name (if not institution, give	street and number)			4b. City,	Town, or	Location of		Decembe		c. County of Deat	10:20A M	\dashv
			Gilchrist Hospice				Tows						Baltimore		
Funer Direct	_		5. Social Security Number 6. So 214–22–1743	ex	(In yrs. las	t birthday) 87 _{Yrs.}	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bird (Month, Da	y, Year)	Co	hplace (State or Foreign untry)	'
d d		ا	Usual Residence of Decedent 10a. State 10b. County				-Ai				August	2/,	1925 Mai	yland	4
arylan ta-fsh	1	ec10	Maryland Baltimon	re	_	Town or Loc thorpe								10d. Inside City Limits 1 ☐ Yes 2√√√ No	
the M	1	5	10e. Street and Number		narc	chorpe	10f. Zip	Code				10g. C	Citizen of What Co		\exists
th with		2	2616 Braun Ave.				212						ted Stat	es	
6 er dea or iter	1	9	11. Marital Status 1 ☐ Never Married 2 ☒ Married	12. Was Decedent E Armed Forces? 1 Yes 2 2	ver in U.S. No	"	Yes, spec	ity Cubai	n, Mexican,	in? (Spec Puerto P	cify Yes or No- Rican, etc.)		14. Race - Ame Black, White	e, etc.	
003 urs aft turel", af Exa		9	3 Widowed 4 Divorced	If Yes, Give Year or Dates.		1	☐ Yes	2 🔼 No	Specify:				Specify: V	Mite	
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and be filed inital Hi ced oth												Maidei	n Surname)		
fary! should! and Me		ŀ	19a. Informant's Name/Relationship (7)			19b. Mailin	g Address					r. City o	or Town, State, Zij	Code)	\dashv
p, M ind 2 s lealth m 27 i			Edward E. Hardest	er,Jr./So					ve.,Aı	rbutı	ıs,Mary	lan	d 21227	·	
Baltimore, Maryland 21215-0036 permit. Pege 1 and 2 should be filed within 72 hours after Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturel", o any lnjury or other traumatic event, the Medical Exam	1	1	20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐		cen	netery, crem	atony or of	her nlace	e)	_	ate		Location - City or .kridge, M		
Baltimore permit. Pege 1 a Department of H Important: If ite any Injury or ott	ą l	ł	4 ☐ Donation 5 ☐ Other (Specifications) 21. Signature of Funeral Service Licens		rieau										⊣
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Pnysicia Medic	_	l	disease or condition resulting in death)	a. Due to (or as a	A 12	ACLU	NOI) <i>i</i>	te	de	RRH	AL	0	Onset and Death	4
Examin	ш.		Sequentially list conditions	b											
ed sit			Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Existo (or as a	nonsequer	nea cryr									
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box death c	Physician	DICIO I	in the past 12 months? 1 Yes 2 No	1 Live Birth 4 Pregnant at 9 Unknown	2 ☐ Fetal of time of dea	death 3 🗌 ath 5 🗌	Ectopic p Other (sp	regnanc ecify)	<i>y</i>				23d. Date of de Month	Day Year	
that the coned by the deteched	10		9 Unknown Part II. Other significant conditions co		it not result	ting in the ur	derlying	ause aiv	en in Part I		00- 004			the cause of death?	\dashv
S, T lifes th signer ld be c	1	2. I	HYPERTON		at not result	ang in the di	idenying e	ause giv	on in Faici.					robably 4 Unknown	n
ord w requ is beer 2 shou	potolemo		Demont	0							24a. Was	an	24b. Were au	topsy findings available	_
The le	18										autor perfo 1 Yes	rmed2	death?	completion of cause of	
DIVISION OT VITAI HECONGS, tal or Attending Physician: The lew requires rs after death. In Director: After this certificate has been signed in by the funeral director, page 2 should be the bound to the funeral director.	á	5	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:				Otho	ce of Death					1400000	5
OT V 19 Physicer this neral d	P		27. Manner ath	1 Inpatie	y 2	R/Outpatient 8b. Time of injury	-	Bc. Injury	4 ⊔ Nur at		ne 5 🗌 Resid 8d. Describe h		6 Other (Specury occurred	ity) ItOSPICE	\dashv
tendir death. for: Aff		3	1				М		Yes 2 🗆 I	No			231		_
DIVISION OT VITAI HECONDS, P.O. BOX 63 to the Hospital or Attending Physician: The lew requires that the death cert within 24 hours after death. To the Funerel Director: After this certificate has been signed by the ettendin completely filled in by the funeral director, page 2 should be deteched for use			4 Homicide determined	28e. Place of Inju building, etc	ry - At hom . <i>(Specify)</i>	e, farm, stre	et, factory	office		2	8f. Location (S City or Tow		nd Number or Ru e)	al Route Number,	
fospita 4 hours unere ely fille	Modical		29a. Certifier 1 Certifying Phys	sician: To the best of r	my knowled	dge, death o	ccurred at	the time	, date and p	place, and	d due to the ca	ause(s)	and manner as st	ated. cause(s) and manner state	
o the lattin 2 or the lattin 2 or the lattin 2	Ž		only one) 3 Certifying Nurs 29b. Signature and title of certifier	se Practitioner: To the	best of my	knowledge,	death occu	rred at th	e time, date	and plac	e, and due to t	he caus	se(s) and manner a	s stated.	-U.
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10 M		ŀ	30. Name and address of person who c	ompleted cause of de	eath (Item 2	3a) (Type, Pr	int)	- 1	000	1		_	0	1-1016.	\exists
. 1)	tate	_	31. Date filed (Month, Day, Year)	4 Registra	r's Signatur	e 6.1	101	100	RT/+C	MA	RIGS.	TR	OT DAL	TIMORD IVIL	7
Regis			nec 1 8 201	2	. 1	-	N.				_				

DHMH 17 Rev 06-2011

DHMH 17 Rev 7/2009

State Registrar m Cu

DON

31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signa

KIM. J. M.D

22832

5808 MAIN STREET, ELKRIDGE,

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** lashington Melical Cepter 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months **Director** 217-80-3927 1 □ M 2 😾 F Aug. 12, 1956 Maryland 56 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10d. Inside City Limits 10a State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland **Funeral Director** 1 Tes 2 X No Maryland Anne Arundel Pasadena 10g. Citizen of What Country? 10f. Zip Code 8549 Neptune Drive 21122 USA items ; 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. "natural", or þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Completed er than "natur the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 10 Homemaker Household other 1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ္ပ Joseph Clarke Ruth Wood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8549 Neptune Drive, Pasadena, MD 21122 Jim H. Holden - Husband Health a item 20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Cem. 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a Department of H Important: If ite 1 X Burial 2 Cremation 3 Removal from State Dec. 11,2012 Elkridge, injury o 4 Donation 5 Other (Specify) 21. Signature Funeral Service Licensee any inj once, 22. Name and Address of Facility Stallings Funeral Home, PA <u>3111 Mountain Rd., Pasadena, MD 21122</u> enter the mode of dying, such as cardiac or respiratory arrest. 23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one Interval Retween Immediate Cause (Final disease or condition Physician/ week Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p as IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ Live Birth 2 - Fetal death in the past 12 months? Month ō Dav Pregnant at time of death 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? ate has bage 2 s 1 Ves 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: မ 1 Depatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death

1 Natural

2 Accident Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1 Yes 2 🔲 No Accident Suicide Investigation within 24 hours after death

To the Funeral Director; A

completely filled in by the 6 🗍 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number 240 29b. Signature and Drive, Glan Burnie, MD 21061

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2012 40987 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12 Month Physician/ 2012 14 11:27P M Henrietta Elizabeth Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Baltimore Washington Medical Center Glen Burnie . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days 93 **Director** 212-18-8186 12/7/1919 MD Usual Residence of Deci 10a, State filed within 72 hours efter death with the Maryland 27 is marked other then "netural", or items 23e or 28e-f sho treumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d, Inside City Limits Director MD Anne Arundel Glen Burnie 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21061 USA 12 Proctor Ave 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Henrietta Armed Forces? Black, White, etc. "neturai", or 1 Never Mamied 2 Married δ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 🗶 No Specify: 3 XXWidowed 4 ☐ Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Clerk Montgomery Ward 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ 9 Thelma Howard Immler Keyser t. Pege 1 end 2 should by trient of Health and Mer rtent: If Item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Virginia Tyler / P.O.A. Centreville, MD 21617 217 Easy Lane ortent: if item 27 injury or other t Itimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) MD Veterans Cemetery 12/21/2012 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) permit.
Departr
Importa
any inju 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 1)~ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami To the Hospital or Attending Physicien: The law requires thet the death certificete be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit this certificate has been signed by the attending physicien and ral director, page 2 should be detached for use es the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: f yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed? 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ၉ 1 Inpatient 2 FR/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28h. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. The deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 061726 1 mul 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 009 31. Date filed (Month, Day

ORIGINAL

State Registrar

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Nar	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, Print)			ig Address (Street a					own, Stat	~ ~	ode)	
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			30. Name and address of person who completed cause				0	0 0	altin				,	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ THADDEUS 2012 Medical a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Iniversity Maryland Medical Cent BALTIMORE 0 Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) Director 1 XM 2 - F 213-41-6596 Feb. 21, 1956 Nigeria 56 Usual Residence of Decede 10d. Inside City Limits 28a-f show 10c. City, Town or Location notified at **Funeral Director** 1 X Yes 2 No Prince George's Hyattsville 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number ms 23a or must be n 20781 Nigeria 4203 Oglethorpe Street iral", or items? 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc Completed by 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: African 3 Divorced event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.
It is marked other than traumatic event, the Me College (1-4 or 5+) Elementary/Secondary (0-12) Private Medical Doctor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Benadette Nwackocha Allyosius Imo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3203 75th Avenue #101, Landover, MD 20785 Health a Felix Onyeise/Cousin Baltimore, t: If item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. 4 Donation 5 Other (Specify) 12/31/2012 | Otulu Amumara, Nigeria Family Plot 22. Name and Address of Facility J.B. Jenkins Feuneral Home, Inc. Signature of Funeral Service Licensee 7474 Landover Road, Hyattsville, MD 20785 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASPIRATION PNEUMONIA Physician/ disease or condition resulting in death) Medical Encephalopa Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) physician Certificate: To Be Completed by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐ 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Varentepalty 1 Yes 2 No 3 Probably 4, Unknown 24b. Were autopsy findings available 24a. Was an Was ...
autopsy
performed?
Yes 2 ... prior to completion of cause of death? 2 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DDA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending n 24 hours after death. e Funeral Director: Af eletely filled in by the fu Investigation Could not be 2 Accident
3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the basis of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) To the within 2 To the comple 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 11, 17, 2012 D69490 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHVA GANJI, 22 S GREENE ST, BACTIMORE, MD 32. Regist ar's Signature State Registrar

Martha Ivey

			For State Registrar	State of Mary			nt of Hea te of De		Mental H	lygiene Reg. No	7111/	40990
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Baltimore,	Page ent o nt: If y or		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification of the content o	Removal from State	Bayvie Bayvie	position (N rematory of W Cr	ame of cother place) emator	ry 12	Date 2/17/1		ocation - City or To altimor	
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Division	ospital or Attendi hours after death. uneral Director: A ily filled in by the fi	Certification: To	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined		At home, farm, Specify)	street, fact		s 2□No	28f. Locatio City or	on (Street a Town, Stat	and Number or Ru te)	ral Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical C	29a. Certifier 1 ☑ Certifying Ph (Check only one)	nysician: To the best of miner: On the basis of ex and manner stated	amination and/o	eath occurr r investigat	ed at the time, on, in my opin	date and pla ion, death oc	ace, and due to ocurred at the ti	the cause me, date a	(s) and manner as nd place, and due	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier			1	9c. License n		39		ate signed (Month	
	H//	ate.	30. Name and address of person who Dr. Masoud Did 31. Date filed (Month Day Year)	completed cause of death anamin 9 32. Registrar's	(Item 23a) (Typo) OOO From Signature	oe, Print) UNK	in Squ	lare	Drive	Balt	imore M	ND 21236
	Sta Regist		31. Date filed (Month, Day, Year)	Maria & A	hour	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 40991 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12/15/2012 Physician/ John I. Jenkins 2:58 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carroll Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Director 191-28-1610 1 X M 2 □ F 74 12/23/1937 PA permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or items 23a or 28e-f show eny Injury or other traumetic event, the Madical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Carroll Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5609 Elele Ct. 21784 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give 1 Yes 2X No Specify: Completed 3 X Widowed 4 ☐ Divorced Specify: Year or Dates. unknown White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Teacher Baltimore City Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ Isaac Jenkins Mary unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maureen Simons/Daughter 5609 Elele Ct., Sykesville, MD 21784 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 1 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Crematory | 12/18/2012 Winfield, MD 22. Name and Address of Facility.
Burrier-Queen Funeral Home & Crematory, P.A.
10.10 T. Ald Tiberty Rd., Winfield, MD 21784 21. Signature of Funeral Service License Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on leach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Que to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed ate has been signed by the attending physician end page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Month Day Year q 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by WYT 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 autopsy performed Yes 2 No 1 🗌 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 ☐ Yes 2 ☐ No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 Yes 2 No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ompleted cause of death (Item 23a) (Type, Print) 0

State Registrar

Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

32. Registrar's signatura

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death TOSHI Physician/ +EM LATA DECEMBER Day 3 2012 Medical 4a. Facility Name (if not institution, give street and nun Examiner 5 DWA . Age (In vrs. last birthday) If Unde 8. Date of Birth (Month, Day, Ye Birthplace (State or Foreign Country) **Funeral** 1 M 2 X Director N/A 29 1983 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director traumatic event, the Medical Examiner must be notified 1 🗌 Yes 2 🔀 No Owings Mills MD Baltimore 10e. Street and Numbe 0 10g. Citizen of What Country? 23a Funeral 21117 India 9352 A Esplanade Court items within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Hygiene. other than "natural", or i 1 ☐ Yes 2 🔀 No If Yes, Give 1 Never Married 2 X Married þ Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify 3 Widowed 4 Divorced Specify: Completed Asian Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Pushpa Joshi B.C. Joshi 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Devarshi Pant / Husband 9352 A Esplanade Ct. Owings Mills, MD 21117 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place. 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 12/17/2012 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, Maryland Signature of Funeral Service Licens Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a ADVANCED METASTATIC CARCINOMA OF BREAST Onset and Death Immediate Cause (Final Praviolem disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last and tran Due to (or as a consequence of) physician s the burial burial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 attending pl IF FEMALE: yes, outcome of pregnancy
Live Birth 2 🗀 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 X Yes 2 No
9 Unknown Month Year Pregnant at time of death by the a 9 Unknown 2012 AUG/VS7 signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed certificate Yes 2 🛮 No 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Tes 2 X No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 Pending 1 Tyes 2 🗌 No death. Accident Investigation Director: / Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined after City or Town, State) thin 24 hours a the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and 140 DS4288

5√

DHMH 17 Rev 7/2009

State

Registrar

RANGARAJAN

Registrar's Signature

NORTHWEST HOSPITAL CENTER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAMASWAMY

8

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary Genevieve Jordan Month De C Year SU) 12 1009PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Agnes Hospital Baltimore Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 215-24-5569 Director 1 □ M 2 ⋤ F 84 11/16/1928 Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Evanniner must be notified at 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Halethorpe 1 Yes 2 XNo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1241 Brewster St. Funerai 21227 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. "natural", or ģ 1 Never Married 2 Married 1 Yes 2 No 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify:White 3 Nidowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Clement Mooney Frances Eleanor Horris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1101 Saint Paul St. Apt. #1806, Baltimore, MD. 21202 Andrea McKenzie /Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) MD Vet Crownsville 12/19/2012 Glen Burnie, MD 21. Signature of Ineral Service Licensee 22. Name and Address of Facility Ambrose Funeral Home 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician SEPTIO JHOCK disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any leading to immedicause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 5 Other (specify) Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? FAILMRE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☐ No Yes 2 No æ 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 1 Matural 5 Pending work? 1 ☐ Yes 2 ☑ No ☐ Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 To the F 29b. Signature and title of certifie Unicoloth P25481 14, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAUTIMOKE, MD AGNES 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State of	Marylan		tificate of L		iu ivieritai r	Reg. No		
	Physicia		1. Decedent's Name (First, Middle, Le Joyce Elai	,	ohnson				2. Date of Decen	Death	2,0,201	у <u>Г</u> тір Ф Ф Ц 2 0530 м
	Medic Examin		4a. Facility Name (if not institution, giv	e street and numb	per)		4b. City, Town, or				. County of De	
	Funeral	-			. Gente 7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24		Birth Day, Year)	9. B	irthplace (State or Foreign ountry)
	Director		178–32–1923 Usual Residence of Decedent	1 □ M 2 🛣 F	71	Yrs.	Worting Days	riouis		,1941		nnsylvania
	yland f shov ed at	ctor	10a. State 10b. County			y, Town or Loc					·	10d. Inside City Limits
	r 28a- notifii	Director	PA Cambri	a	Jo	hnstow	n 10f. Zip Code			100 0	tizen of What C	1 X Yes 2 No
	with th	Funeral	711 ½ Menoher E	Blvd.			15901			Tog. Ci	USA	ountry :
030	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deced Armed Ford 1 Yes If Yes, Give Year or Dat	ces? 2 X No		Vas Decedent of H f Yes, specify Cuba		n? (Specify Yes or Noverto Rican, etc.)	10-	14. Race - Am Black, Wh Specify:	
0500-CLZ	2 hour "natur edical	Completed	15. Decedent's (Specify only highest g		-	(Give k	lent's Usual Occup	ation during most o	f working	16b. k	(ind of Busines	s/Industry
717	within 7 giene.		Elementary/Secondary (0-12)	College (1-2			O NOT use retired) cher			Sch	noo1/Ed	ucation
yland	e filed v ntal Hyg ed othe event,	To Be	17. Father's Name (First, Middle, Last)						s Name (First, Midd		Surname)	-
	ould by nd Mer mark matic	_	Leroy F. Johnso			19h Mailin	a Address (Street		che Ander		r Town, State, 2	Zip Code)
е, маг	nd 2 sh ealth ar n 27 is er trau		David Johnson -	- Son		-1-			ve, Arlin	-		2203
baitimore	Page 1 arment of Hisant: If iter		20a. Method of Disposition 1 🔀 Burial 2 🗌 Cremation 3 🖟 4 🔲 Donation 5 🗀 Other (Spec	cify)	State C	emetery, crem	sition (Name of natory or other place wn Cemete	ery 1		Jol	ocation - City o	, PA
pall	permit Depart Import any inj once.		21. Signatur, of Funeral Simice Licer	nsee ud S	20				Metropol et, Alexa			Service 22310
_,	hysician/		23a. Part 1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition	mplications that ca one cause on eac	aused the deat h line.	h. Do not ente	er the mode of dyin	g, such as ca	rdiac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)	a. Due to (as a consequ	uence of):	12 1 10	. //				211000
	_ #	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to fo	or as a consequ	uence of):	LUVY NO	uure	- 1			3 years
	icate be executed physician and sthe burial-trans	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (c	muna or as a consequ	uence of):	rferial	446	en tens	On		1 years
20/	cate be physic s the b	edic	•	d								
BOX 08	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affar death. To the Funeral Director: Affar this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 M No 9 □ Unknown		irth 2 Feta ant at time of o	aldeath 3 🗌	Ectopic pregnand Other (specify)	су		-	23d. Date of d Month	elivery Day Year
JS, P.O.	luires that the	by	Part II. Other significant conditions	contributing to de	ath but not res	sulting in the u	nderlying cause gi	ven in Part I.				to the cause of death? Probably 4 Unknown
Records,	The law rec cate has bee	Completed							р	/as an utopsy erformed? es 2 X N	prior to death?	autopsy findings available completion of cause of les 2 \(\sum \) No
VItal	sician: certifi lirector	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	npatient 2 🗆	EB/O: to ation	Oth	or:	(Check only one)		C	
V TO UC	nding Phy ath. r: After this ne funeral d	icate: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date o (Month		28b. Time of injury	28c. Injur work	y at	28d. Describ			ecny)
DIVISION OF	al or Atte s after de il Directo ed in by th	Certificate	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	28e. Place	of Injury - At ho g, etc. (S <i>pecif</i> y		eet, factory, office			n (Street ar Town, State		lural Route Number,
_	ne Hospitt n 24 hour ne Funera pletely fille	Medical	29a. Certifier 1 Certifying Ph (Check 2 Medical Exar only one) 3 Certifying Ny	niner: On the basis	s of examination	n and/or invest	igation, in my opini	on, death occi	lace, and due to thurred at the time, dated and place, and due	te and place	e, and due to the	e cause(s) and manner stated.
	To the with com	17	29b. Signature and title of contifier	per	ayu	D.	29c. Licens	e number 28/	95	29d. Da	ate signed (Mor 2 -//	oth, Day, Year) -3012
			30. Name and address of person who	completed cause	of death (Item	23a) (Type, P	Tint) D	Che	verly A	1.1)	2078	-2012
	Stat Registra		31. Date filed (Manth Day, Year) —— DEC 1 8 20	/ /	gistrar's Signa	ture	4.1	01100				

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ 2012 4:10 P M December Alieh K. Jaber Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville Hebrew Home of Greater Washington r 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕅 Days (Month, Pay, Year) ct. 1, 1915 Hours Country) 223-35-1950 Iran Director 97 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be matter at a 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Rockville Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20852 United States 6121 Montrose Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 💢 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White Completed 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Khanoom Agha Nabavi Javad Parviz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20852 7202 Old Stage Road, Rockville, Maryland Shirin Goldberg/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State December Norbeck Memorial Park 14, 4 Donation 5 Other (Specify) 2012 Olney, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home, Rock 300 W. Montgomery Avenue, Rockville, 21. Signature of Funeral Service Licenses Rockville, Inc. 11e, Maryland 20850 Mallia M01173 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying ner Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and the burial-trar Due to (or as a consequence of): resulting in death) Last 24 hours after death.

• Funeral Director: After this certificate has been signed by the attending physician eted filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death Unknown 2 10 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 No ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 27. Manner eath Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 3 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Dav. Year)

Registrar
DHMH 17 Rev 7/2009

State

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mon

Year)

31. Date filed (Month, Day,

Zoovia

Aman,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Physician/ Marke Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9825 Gwynn Park Drive Ellicott City Howard If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Director 216-78-7953 1 □ M 2 T F 49 Yrs. March 5, 1963 Maryland 28e-f shov 10a. State th end Mental Hygiene. 27 is merked other then "netural", or Items 23e or 28e-f shor treumetic event, the Medical Examinar must be notified at 10h Counts 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Maryland Howard 1 Yes 2 XNo Ellicott City 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral **USA** 9825 Gwynn Park Drive 21042 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian Black, White, etc. Yes 2 X No Yes, Give ģ 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Manager Food Services Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Page 1 and 2 should be Joan Nieberlein Edward Kraft Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Item 27 9825 Gwynn Park Drive Ellicott City, MD 21042 Edward Kraft, Father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of Importent: If It eny Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 12/18/12 Baltimore, Maryland 21. Signature of Funeral Service Licenses Thomas Gregor Cremation Society Of Maryland, 299 Frederick Road Baltimore, Inc. Maryland 21228 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one caus Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physicien: The lew requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the ettending physicien and completely filled in by the Innerial director, page 2 should be deteched for use as the burlet-transit Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month 1 Yes 2 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 2 (No Other: 4 Nursing Home 5 M Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Many of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred ✓ Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 2012 31. Date filed (Month, Day, Year) **NFC. 1** 8 2012 32. Registrar's Signa State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER Norbert Thomas Kurek 5:50P M 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death SAINT JOSEPH MEDICAL CENTER TOWSON BALTIMORE . Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Hours (Month, Day, Year) Director 212-26-7716 1**∑** M 2 □ F 82 Yrs 1930 Jan 31. Maryland Usual Residence of Decedent 28a-f ehov 10b. County death with the Meryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2 No Baltimore Parkville 10e. Street and Number ō 10g. Citizen of What Country? Items 23e 1353 Dalton Road 21234 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? 1951

If Yes, Give 105 Black, White, etc. "naturel", or Completed by 1 Never Married 2 Married within 72 hours efter If Yes, Give Year or Dates White 1 Yes 2 XNo Specify. **Maryland 21215-003**(1954 Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be flied within 72 h. Department of Health and Mental Hyglena. Important: If Item 27 is marked other then "na eny injury or other traumatic event, the Madia once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Home Improvement Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francis Jacob Kurek Mary Josephine Bier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Mairose, Niece 1353 Dalton Road Parkville. Maryland 21234 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 12/14/12 Baltimore, Maryland 21. Signature of Funeral Service Leginsee Thomas Gregor Cremation Society Of Maryland, 299 Frederick Road Baltimore, Inc. Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CONGESTIVE HEART FAILURE Immediate Cause (Final -Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner CHRONIC OBSTRUCTIVE PULMONARY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): CHRONIC RENAL FAILURE or Attending Physicien: The lew requires that the deeth certificate be executed ettending physician end for use es tha burlai-transi that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year signed by the e lid be deteched f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown this certificate has been signal director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 I DOA 24 hours after deeth.

Funerel Director: After this letely filled in by the funerel of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1.2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. The deficiency in the desis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certife 29d. Date signed (Month, Day, Year) 13/12 DO015452 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21204

Registrar DHMH 17 Rev 06-2011 TIMOTHY

31. Date filed (Month, Day, Year)

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18 2012

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32. Registrar's Signature

7601 OSLER DRIVE TOWSON MD

				For	State of Mary	yland / Depa					-		9.5.0	1 0000
		24.5000		State Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate	of D	eath			leg. No2) 2_	40998
		Physicia	n/	Frederick Nichola	s Kief						2. Date of Dea Decembe	Day	20 1 2	3. Time of Death 6:00 PM
1	4	Medic Examin		4a. Facility Name (if not institution, give stre					Location o			4c. Cour	nty of Death	
	and the			8802 Walther Blvd 5. Social Security Number 6. Sex		ace 2115	Pa:	kvi	11e	24 Hrs	8. Date of Birth		ltimo	CE place (State or Foreign
		Funeral Director			M 2 □ F	84 Yrs.	Months	Days	Hours	Min.	(Month, Day	, Year)	Coun	try)
		t ow		Usual Residence of Decedent 10a. State 10b. County	110	Dc. City, Town or Loc	ation				Dec 23	, 1927		yland Od. Inside City Limits
		arylan a-fsh ified a	Director	Maryland Baltimon		•	rkvil	16						1 ☐ Yes 2 😾 No
		the M or 28	ä	10e. Street and Number	.e		10f. Zip					10g. Citizen o	of What Cour	ntry?
		h with ns 23a must t	Funeral	8802 Walther Blvd			<u></u>	2123				US		
		or iten	by Fu	11. Marital Status 12 Never Married 2 ☐ Married	 Was Decedent Ever Armed Forces? 1 K Yes 2 □ No 	1945	/as Decedo Yes, speci	ent of His fy Cubar	spanic On n, Mexican	gin? (Spec 1, Puerto f	cify Yes or No- Rican, etc.)		lace - Americ lack, White,	etc.
200	3	ırs afte ural", Exan	ted b	3 X Widowed 4 □ Divorced		1947 1	☐ Yes 2	X No	Specify:			Spec	ify: W	hite
i i	2	72 hou n "nat fedica	Completed	15. Decedent's Educ (Specify only highest grade	completed)		ent's Usua ind of wor NOT use	done d		t of workin	ng [16b. Kind of	Business/In	dustry
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7	2	e filed tal Hyg ed oth event	To Be	17. Father's Name (First, Middle, Last)							(First, Middle, i	Maiden Suma	nme)	
	<u> </u>	ould be d Men marke matic		Henry Kief 19a. Informant's Name/Relationship (Type	Printl	10h Mailin	a Addroon	(Street o			ceamer Route Number	City or Town	State Zin (Cadal
2	Z	d 2 sho alth an 27 Is r trau		Cecilia M. Smith,	•		~							d 21128
7	o G	of Head		20a. Method of Disposition 1 Burial 2 Coremation 3 Re		20b. Place of Dispo- cemetery, cren	sition (Nam	e of her place			ate	20c. Locatio	on - City or To	own, State
7	Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 ☐ Donation 5 ☐ Other (Specify)		Metro Cre				12/14			more,	Maryland
13/2012	n D	Depa Impo any is		21. Signature of Funeral Service License	Thomas Gr	egor 2	remat 99 Fr	ion eder	Soci	ety (Road	Of Mary Balti	land,	Inc. Maryla	nd 21228
3				23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one	at or's that caused the									Approximate Interval Between
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ed		Medical Examiner		resulting in death)	Due to (or as a co	onsequence of):								
			iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a co	onsequence of):								
		oe executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a co	onsequence off.								
	~ .		ख्र	d d										
J.	200	tificate ng phy nas the	Medi	IF FEMALE:										
	POX P	ath cert attendii for use	jan/	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of p 1 Live Birth 2 L 4 Pregnant at tir	Fetal death 3	Ectopic p		у				Date of deliv Month	ery Day Year
	ă.	the dea by the a	Physician/Medi	1 Yes 2 No 9 Unknown	9 Unknown		outer (a)	-						
2	7. D	s that 1 gned b be deta	室	Part II. Other significant conditions cont	ributing to death but	not resulting in the u	nderlying (ause giv	en in Part	I.		1		he cause of death?
· 5	rds	require been si should	eted								24a. Was	7		psy findings available
ederic	of Vital Records,	e has l age 2 s	Completed								autor perfo		prior to co death? 1 ☐ Yes	impletion of cause of
3	<u> </u>	ian: Ti ertifical ctor, p	BeC	25. Was case referred to medical examiner?					ace of Dea	th (Check		20 110	1 10 103	2 23 110
4	<u> </u>	Physic this ce al dire	은	1 ☐ Yes 2 ☑ No Ho 27. Manner of Death	ospital: 1 ☐ Inpatient 28a. Date of injury	2 ER/Outpatier		Othe 8c. Injury	4 ∐ N		me 5 Resid			v)
اسلسا	0	ath. : After e funer	cate	1 Accident Investigation	(Month, Day, Y		M	work			28d. Describe n	ow injury occ	urreu	
	Division	or Atter	Sertif	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (\$	- At home, farm, str Specify)	et, factory	, office			28f. Location (S City or Tow		mber or Rura	l Route Number,
í	בֿ	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Medical Certificate:	29a. Certifier 1 Certifying Physic (Check 2 Medical Examine	ian: To the best of my	/ knowledge, death o	occurred at	the time	e, date and	d place, ar	nd due to the ca	ause(s) and m	anner as stat	ted. ause(s) and manner stated.
		o the Print 2 of the Promplet	₹	only one) 3 _ Cartifying Nurse 29b. Signature and title of cartifier	Practitioner: To the b	est of my Imawledge	death acc	urned at t	he time de number	atic and pla	ce and due to t	29d. Date sig	nd manner as	stated.
4		->-0		1	<u>wo</u>		7	DJ 3	3117	_	(H 2012
		15+V		30. Name and across of person who con	appleted cause of deat		Print)	Pa	/kvil	le r	m 2	1234	(
	F	Sta Registr		81. Date filed (Month, Day, Year) DEC 1 8 2012	32. Registrar's	Signature								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Deceber Physician/ 15° 2012 3:29 AM Samue1 Keker Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chevy Chase 5610 Wisconsin Ave. Montgomery Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours Country) Director 579-07-6541 1**XX**M 2 □ F 95 April 4, 1917 Colorado Yrs Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at death with the Maryland Director MD Montgomery Chevy Chase 1 X Yes 2 ☐ No 10e Street and Number 10f. Zip Code 10g Citizen of What Country? Funeral #702 20815 5610 Wisconsin Ave. United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Armed Forces?

1XXYes 2 \sum No WWII Black, White, etc. ð 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🗓 No Specify: If Yes, Give Year or Dates. Korean Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Business Executive Media Publication Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic even once. and Mental His marked of Keker Eleni Economu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5610 Wisconsin Ave., #702, Chevy Chase, MD Lucy Keker / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State Chesapeake Crematory 12/18/2012 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD Name and Address of Facility app Funeral and Cremation Services 33 Gist Ave., Silver Spring, MD 21. Signature of Funeral Service M00382 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final -₹nysician/ oneumon disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 D Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Year Pregnant at time of death Yes 2 □ No ed by the a g Unknown g Unknown n signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed peen 24a. Was an Were autopsy findings available prior to completion of cause of After this certificate has I funeral director, page 2 s autopsy performed No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) 1 Tyes 욘 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Director: / 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one thin the 29b. Signature ar ₹ 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALZMAN

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, = For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deatl Month Physician/ 35 Medical 4a. Facility Name (if not intitution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Oak Crest Village Parkville Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours 220-09-3680 Director 1 M 2 TXF July 7, 1921 91 |Maryland Usual Residence of Deceden or 28a-f show a notified at 0a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 X No MD Parkville Baltimore 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or Funeral 8830 Walther Blvd 21234 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. I should be filed within (2 fireway). the and Mental Hygiene.

It is marked other than "natural", or item

If is marked other, the Medical Examiner. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည Charles E. Beacht Phoebe N. Moore Department of Health and Important: If item 27 is n any injury or other traumonce. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3714 Keene Avenue; Baltimore, MD 21206 Jeanne A. Niermeier Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Park Cemetery 12/19/12 Baltimore, MD 22. Name and Address of Facility Sterling Ashton Schwab W Funeral Home of Catonsville, Inc. 4 ☐ Donation 5 ☐ Other (Specify) Witzke 21. Signature of Funeral Service Licenses 1630 Edmondson Avenue; Catonsville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) r as a consequence of) **Examiner** Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exam and burial-tra Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death cert ficate be the be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death g Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Onknown To Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed' 2 No Yes 2 Vital Hospital or Attending Physician: funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 🔲 Yes Natural 5 Pending Division within 24 hours after death To the Funeral Director, A 2 🗌 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie cause of death (Item 23a) (Type, Print 30. Name and address of person who complete wether 31. Date filed (Month, Day, Year) State 18 DEC Registrar DHMH 17 Rev 06-2011

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